

1
FOR STATE
HEALTH DEPT.
(M)
X
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00093

Item Id, Phone call, Med. Ex. Office 1/23/61 mb

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>In car at Laurel Race Track</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MASS</u> b. COUNTY <u>BROOKLINE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>58X-3</u> d. STREET ADDRESS <u>211 ST PAUL ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Frank</u> First Middle Last 4. DATE OF DEATH <u>1</u> <u>14</u> <u>1961</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Andolino</u> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HORSE OWNER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RACE HORSES</u> 11. BIRTHPLACE (State or foreign country) <u>ITALY</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>SALVATORE ANDOLINO</u> 14. MOTHER'S MAIDEN NAME <u>EPISANIA ALESSI</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>024-03-2994</u> 17. INFORMANT <u>PAUL ANDOLINO</u> Address <u>211 ST. PAUL ST.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> 420-1 DUE TO (b) <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/15/61</u> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Will. Ford</u> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>1/19/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>ST MICHAEL</u> 22d. LOCATION (City, town, or country) (State) <u>Boston</u> <u>MASS.</u>		23. FUNERAL DIRECTOR <u>Frank Della Voce</u> ADDRESS <u>322 S. HIGH ST</u> DATE <u>JAN 17 '61</u> 24a. REC'D BY REGISTRAR <u>Conrad S. Krum</u> 24b. REGISTRAR'S SIGNATURE			

FOR STATE



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10098

603 - EXAMINER'S CERTIFICATE OF DEATH

STUDENTS

TO PAID ST.

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TEST

MISSISSAUGA ALBERTA

STUDENT'S RECORD

STUDENT'S RECORD

STUDENT'S RECORD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00094

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>WASHINGTON, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH., D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 2, Box 874 - SEVERN AVE.</u>				d. STREET ADDRESS <u>3109 6th ST. S.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE THERESA ANGLE</u>				4. DATE OF DEATH Month Day Year <u>JAN. 4th 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 MARCH 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>WASH., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>YES</u>	
13. FATHER'S NAME <u>JOS. ATWELL (DEC.)</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN (DEC.)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>ELMER KING (son) RT 2, Box 874 - Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION</u> DUE TO (c) <u>CARDIO-VASCULAR-RENAL DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 YRS</u> <u>10 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FELL OUT OF BED 3 DAYS AGO - MASSIVE HEMORRH OF FACE & LT. LEG.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SEE ABOVE</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 1959</u> , to <u>present</u> , 1961, that I last saw the deceased alive on <u>JAN 3</u> , 1961, and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>H.F. Manuzak</u> M.D. <u>425 S. RITCHIE HWY</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>H.F. MANUZAK, M.D.</u> <u>GLEN BURNIE, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/7/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem</u>		22d. LOCATION (City, town, or county) (State) <u>COLMAR MARSH PR. GEO CO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Clifton S. Hanna</u>	

TO HO. 1
AL DIRECTOR: After this certificate has been
page 3 should be detached to
Director,
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

085

CERTIFICATE OF DEATH

00095

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 513 Fifth St.,			
3. NAME OF DECEASED (Type or print) Katherine BARBOUR				4. DATE OF DEATH Month January Day 25 Year 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1905	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 25 Hours 19 Min. 61		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James Travis				14. MOTHER'S MAIDEN NAME Hanna Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Mary S.S. Vauls - 513 Fifth St. Anna. Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Pulmonary Congestion 522X DUE TO Acute Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Acute Cardiac Failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) XXXXXX attended the deceased from Jan. 25, 1961 to Jan. 25, 1961, that (I) XXX last saw the deceased alive on Jan. 25, 1961, and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE A. T. Allen				22b. DATE SIGNED 1/26/61			
22c. PHYSICIAN'S NAME (Type) A. T. Allen				22d. ADDRESS 62 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-29-61		23c. NAME OF CEMETERY OR CREMATORY Good Hope		23d. LOCATION (City, town or county) (State) Front Royal - Va.	
24 FUNERAL DIRECTOR'S SIGNATURE C.E. HICKS				25a. REC'D BY REGISTRAR JAN 31 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

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physician.

MEDICAL CERTIFICATION

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James A. Smith - 1000 1st St. N.W., Wash., D.C.

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James A. Smith - 1000 1st St. N.W., Wash., D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
086 CERTIFICATE OF DEATH 00083

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade c. LENGTH OF STAY IN 1b - d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION United States Army Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1536 N. Milton St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BARNETT Middle - Last -		4. DATE OF DEATH Month JANUARY Day 22 Year 19 61	
5. SEX Female	6. COLOR OR RACE Neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12:11 PM 22 Jan 61
9. AGE (In years last birthday) - yrs.		10. IF UNDER 1 YEAR Months - Days -	11. IF UNDER 24 HRS. Hours - Mins 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? -	
13. FATHER'S NAME Alvin Barnett		14. MOTHER'S MAIDEN NAME Janice Wilburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mother - 1536 N. Milton St Balto, Md.		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - aspiration of amniotic contents. DUE TO 760.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Questionable sub-dural hemorrhage. DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that (I) physician attended the deceased from 21 Jan 19 61 to 22 Jan 19 61 that (I) was last saw the deceased alive on 22 Jan 19 61 , and that death occurred at 12:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Roy M. Slezak		22b. DATE SIGNED 22 Jan 61	
22c. PHYSICIAN'S NAME (Type) ROY M. SLEZAK, Capt., M.C.		22d. ADDRESS US Army Hosp Ft Geo G. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 30 Jan 61	
23c. NAME OF CEMETERY OR CREMATORY U. S. A. Hosp		23d. LOCATION (City, town, or county) (State) Ft Geo G. Meade, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Shirley J. Lunden and H. M. S.		25a. REC'D BY REGISTRAR 22 Jan 61	
ADDRESS -		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

State of New York
County of _____
City of _____
I, _____, Registrar of the City and County of _____, do hereby certify that _____
born _____ died _____ at _____
Cause of death _____
Signed _____
Registrar of the City and County of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
087
CERTIFICATE OF DEATH

00096

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach	
c. LENGTH OF STAY IN 1b 8 days		d. STREET ADDRESS 231 Asbury Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Warren Middle Le Roy Last BEVAN		4. DATE OF DEATH Month January Day 12 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1884
9. AGE (In years lost birth day) 76 yrs.		10. IF UNDER 1 YEAR: Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Davis Chem. Co.	
11. BIRTHPLACE (State or foreign country) Williamsport, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Bevan		14. MOTHER'S MAIDEN NAME Clara ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Warren L. Bevan		Address 231 Asbury Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 541.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Hemorrhage Secondary to DUE TO 10 days (c) Chronic Duodenal Ulcer		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric Resection on 1/6/61		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from 1/4 1961 to 1/12 1961 that (I) did last saw the deceased alive on 1/12 1961 , and that death occurred at 2 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Fred Hawkins, Jr. M.D.		22b. DATE SIGNED 1/12/61	
22c. PHYSICIAN'S NAME (Type) J. Fred Hawkins, Jr.		22d. ADDRESS 100 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/61	
23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Jackson & Sons ADDRESS Balto 17, Md		25a. REC'D BY REGISTRAR JAN 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

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CERTIFICATE OF DEATH

087

Blank certificate form with faint horizontal lines and a central circular stamp.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 1,2 FilmG279 1-24-61 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00097

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private Res.</u>		d. STREET ADDRESS <u>14921 BROOKWOOD RD</u>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>S</u> Last <u>BLAKEN</u>		4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 3 - 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>W. Francis Beall</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET YEATLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MR. WM. H. BLAKEN</u>		Address <u>4921 BROOKWOOD RD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma of Breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>W. Hypertensive Cardiovascular disease</u> DUE TO <u>Pathological fracture of humerus</u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arthritis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 15, 1956</u> , to <u>Jan. 13, 1961</u> , that I last saw the deceased alive on <u>1/13/61</u> , 19 <u> </u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>203 YATAPSCO AVE</u> DATE SIGNED <u> </u>				
ACTUAL SIGNATURE <u>Samuel Rubin</u> M.D.		PHYSICIAN'S NAME (Type) <u> </u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-17-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN P. MILLER</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 18 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kravitz</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used if the deceased was in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00098

1. PLACE OF DEATH a. COUNTY <u>Adams</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Adams</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Turners Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Brown</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John W. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Richard Thomas Lethian MD</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>443x</u> DUE TO (b) <u>Retrospective Hypertension Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Vascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1961</u> to <u>1/14/61</u> , that (I) (we) last saw the deceased alive on <u>1/14/61</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard Brown</u>		22b. DATE SIGNED <u>1/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Brown M.D.</u>		22d. ADDRESS <u>10-207 1st Ave S</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-19-1961</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Adams Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Bayard Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25. REC'D BY REGISTRAR <u> </u>	
25a. REGISTRAR'S SIGNATURE <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	

10000

RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
LAND OFFICE
WASHINGTON, D.C.

10000

[Faint, illegible handwritten text covering the majority of the page, possibly a letter or report.]

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

050 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60099

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS Same	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 411 Sixth Street N.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Forrest Burns				4. DATE OF DEATH January 30th, 19 61			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/75	9. AGE (In years, last birthday) 85	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired coal miner.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bellewood Penn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Burns				14. MOTHER'S MAIDEN NAME Rhoda Culberston			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236-09-0332		17. INFORMANT Address Mrs. Etheline Gilbert (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular diseases, Diabetes. 443 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gustave H. Faubert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/30/61	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-61		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Ph.		22d. LOCATION (City, town, or country) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR H. J. Singleton		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. House	
				DATE FEB 6 '61			

MEDICAL CERTIFICATION

100 2141
2141 001

Anne Hummel

Olga Hummel

411 Sixth Street N.E.

James Forrest Burns
x

M

Retired coal miner.

Alexander Burns

No

38-08-0332 Mrs. Etelene Gilbert (deceased)

Hypertensive cardiovascular diseases, Diabetes.

Gustave P. Lafont, N.E.

1/30/81

1
 091
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 C0100

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>Unknown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDDIE</u> Middle <u>CALDWELL</u> Last <u>JAN</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Text</u>	11. BIRTHPLACE (State or foreign country) <u>West Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>James A. Wells</u> Address <u>325 N. Windell Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 443 DUE TO <u>Congestive Heart Failure due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertensive Cardio-vascular Disease</u> DUE TO (c) <u>Arteriosclerotic Hypertensive Cardio-vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>12/23</u> to <u>1/1</u> 19 <u>61</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> 19 <u>60</u> to <u>1/1</u> 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>1/1</u> 19 <u>61</u> , and that death occurred at <u>3:00</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>R. L. Richardson</u> M.D.		22b. DATE SIGNED <u>1/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u> M.D.		22d. ADDRESS <u>150-CLAY ST ANNAPOLIS, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-7-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town, or county) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u> ADDRESS <u>Annapolis Md</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Miller</u>			

MEDICAL CERTIFICATION

STATE OF NEW YORK
CERTIFICATE OF DEATH

100

100



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>Few seconds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore-Washington Express way.</u>				d. STREET ADDRESS <u>178 Cherrydell Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Luthor Glen Collins</u>				4. DATE OF DEATH Month Day Year <u>January 19 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29, 1915</u>		9. AGE (In years last birthday) <u>45</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spring Grove State</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital Employee</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
13. FATHER'S NAME <u>Andrew J. Collins</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Burke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>228 01 0605</u>		17. INFORMANT <u>Jesse W. Collins, Same as 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was walking on Baltimore Express way when he was hit by a car.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1/19/61</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Baltimore-Washington Express way Linthicum, Md.</u>			
20f. (City or town) <u>Linthicum</u>		20g. (County) <u>St. Anne's</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/20/61</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Cove</u>			
22d. LOCATION (City, town, or county) <u>Big Stone Gap, Va.</u>		22e. (State) <u>Va.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>			
23a. ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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010
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
094
CERTIFICATE OF DEATH
C0103

1. PLACE OF DEATH o. COUNTY Anna Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 year 9 mos. 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Pine & Cross Streets	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Cornish		4. DATE OF DEATH Month 1 Day 10 Year 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1896
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cornish		14. MOTHER'S MAIDEN NAME Isabella Laws	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Chronic Brain Syndrome associated with Senility			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/6/1959 to 1/10/1961, that (I) (we) last saw the deceased alive on 1/10/1961, and that death occurred at 8:45 from the causes and on the date stated above.			
22a. SIGNATURE [Signature] M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> January 10, 1961 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/11/61	
23c. NAME OF CEMETERY OR CREMATORY Cambridge		23d. LOCATION (City, town, or county) (State) Camb. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry Funeral		25a. REC'D BY REGISTRAR DATE JAN 13 '61	
ADDRESS 222 Cedar St. Camb		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

80203

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

095

CERTIFICATE OF DEATH

C0104

1. PLACE OF DEATH a. COUNTY Anne Arundale. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Knollwood Nursing Home.				d. STREET ADDRESS Route #1 Box 240.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Davis		4. DATE OF DEATH Month Jan. Day 17 Year 1961					
5. SEX F	6. COLOR OR RACE W	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 17th, 1891	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic.		10b. KIND OF BUSINESS OR INDUSTRY Own-Work.		11. BIRTHPLACE (State or foreign country) Louisa County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Marion Melton.				14. MOTHER'S MAIDEN NAME Dora Madison.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mr. A. A. Dadidson, Millersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the uterus 174 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Hypertension DUE TO (c) none						INTERVAL BETWEEN ONSET AND DEATH 18 months 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1951 to Jan. 17, 1961 that (I) was last saw the deceased alive on Jan. 16, 1961 , and that death occurred at 9 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A. M. McLaughlin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin		22d. ADDRESS 3708 Mountain Rd, Pasadena Md.		22b. DATE SIGNED 1/17/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 20, 1961		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery.		23d. LOCATION (City, town, or county) (State) Gordonsville, Virginia.	
24. FUNERAL DIRECTOR'S SIGNATURE Preddy's Funeral Home		25a. REC'D BY REGISTRAR J. W. Freley		25b. REGISTRAR'S SIGNATURE Arthur M. ...		DATE JAN 23 1961	

1010

CERTIFICATE OF DEATH

003

Name of deceased

Name of deceased

Residence

Residence

Place of birth

Place of birth

Date of death

Date of death

Place of death

Place of death

Place of death

Signature of physician

Signature of physician

Signature of registrar

Signature of registrar

Handwritten signature

Handwritten text

Handwritten date

Handwritten text

Handwritten text at bottom

Handwritten text at bottom

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
096
CERTIFICATE OF DEATH

00105

1. PLACE OF DEATH a. COUNTY <u>GA Co Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>GA Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Odenton GA Co Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Knoll Manor Home</u>		d. STREET ADDRESS <u>1 Mullersville GA Co Md</u>	
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>A</u> Last <u>DISNEY.</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Murray</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Nurs Kathryn Parker</u> Address <u>17 George Ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL CORTICAL INFARCTION</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRO VASCULAR OCCLUSION</u> DUE TO <u>2 months</u> (c) <u>CEREBRAL THROMBOSIS</u> <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL ATHEROMA.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/60</u> to <u>1/5/61</u> , that (I) (we) last saw the deceased alive on <u>1/2/61</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gerard Church</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH.</u>		22d. ADDRESS <u>121 CATHEDRAL ST ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 9-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Fredensville Rd Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin Link</u> ADDRESS <u>426 Green Bay Avenue</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and possibly a signature.]



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-travel permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60106

1. PLACE OF DEATH a. COUNTY <u>ANNE-ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>SAME</u> b. COUNTY <u>SAME</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ODENTON</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SAME</u>			
c. LENGTH OF STAY IN 1b <u>2 years</u>				d. STREET ADDRESS <u>SAME</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Michaels</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GROVER-CLIFTON-DORSEY</u>				4. DATE OF DEATH <u>JAN-31</u> 1961			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/7/93</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from P.R.R. as LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTH PLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NICHOLAS-DORSEY</u>				14. MOTHER'S MAIDEN NAME <u>SUZANNE-QUEEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>717-07-6559</u>			
17. INFORMANT <u>Mrs. Eugenia Dorsey (wife)</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> (e), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>GUSTAVE-H. FAUBERT</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/2/61</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>Blow Breeze, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabo</u>		22d. LOCATION (City, town, or country) (State) <u>Odenton Md.</u>	
23. FUNERAL DIRECTOR <u>William Reese</u>				24. REC'D BY REGISTRAR <u>Anna</u>			
24b. REGISTRAR'S SIGNATURE <u>Anna</u>				DATE <u>JAN 9 '61</u>			

MEDICAL CERTIFICATION

100108

COB MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-8. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

098 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CO107

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Churchton				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Churchton			
c. LENGTH OF STAY IN 1b 2 yrs				d. STREET ADDRESS Franklin Manor			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Franklin Manor				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First H. Middle MALONE Last DRESBACH				4. DATE OF DEATH Month January Day 7 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 26 1914	
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min. 50		IF UNDER 24 HRS. Hours 10 Min. 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY				10b. KIND OF BUSINESS OR INDUSTRY Hutchinson Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Spencer Dresbach				14. MOTHER'S MAIDEN NAME Anna Malone			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. Harry Woodring		17. INFORMANT Woodger Hotel Washington DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds of face and trunk DUE TO 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. shot during altercation DUE TO shot during altercation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) shot during altercation			
20c. TIME OF INJURY Month, Day, Year Jan. 7 1961 Hour a.m. 0:00		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Churchton (County) Franklin Manor (State) Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/8/61	
EXAMINER'S NAME (Type) Charles S. Petty				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) 1/8/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/61		22c. NAME OF CEMETERY OR CREMATORY OAKLAWN		22d. LOCATION (City, town, or country) (State) ELK CITY KANSAS	
23. FUNERAL DIRECTOR Bruce Hardy ADDRESS Salisbury Md				24a. REC'D BY REGISTRAR JAN 16 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

IN SENATE
JANUARY 1, 1901

REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF HEALTH
AND
HYGIENE
FOR THE YEAR
1900

ALBANY:
JANUARY 1, 1901

NEW YORK:
JANUARY 1, 1901

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

099

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00108

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Churchton		c. LENGTH OF STAY IN 1b 2 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Churchton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Franklin Manor				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SHIRLEY S. DRESBACH		4. DATE OF DEATH January 7 1961		5. SEX female 6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 28 1913		9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Elk City, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARTHUR B. Shaffer		14. MOTHER'S MAIDEN NAME Grace W. Woodring	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Harry Woodring		Address Woodner Hotel Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds of trunk DUE TO (b) 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) shot during altercation					
20c. TIME OF INJURY Month, Day, Year 10:00 AM Jan. 7 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Churchton Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/8/61			
EXAMINER'S NAME (Type) Charles S. Petty		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/61		22c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY		22d. LOCATION (City, town, or country) (State) ELK CITY KANSAS	
23. FUNERAL DIRECTOR Bernard Harduty				ADDRESS Salisbury Md		24a. REC'D BY REGISTRAR JAN 16 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60169

100

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey (Hanover P.O.)				c. LENGTH OF STAY IN 1b Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Ave. - Rt. #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HAROLD Middle L. Last DUNKERLY				4. DATE OF DEATH Month January Day 6 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11th June 1909		9. AGE (In years lost birthday) yrs. 51	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		11. BIRTHPLACE (State or foreign country) Dorsey, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chester A. Dunkerly				14. MOTHER'S MAIDEN NAME Cora M. Dunkerly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 111111		17. INFORMANT Mr. Norman Dunkerly (son)		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronechogenic Carcinoma DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) & General Malastasis DUE TO 6 mo (c) Myocardial infarct DUE TO 2 mo							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 4 , 19 61 , to Jan 6 , 19 61 , that (I) (we) last saw the deceased alive on Jan 6 , 19 61 , and that death occurred at 4:45 M, from the causes and on the date stated above.							
22a. SIGNATURE B B Brumbaugh M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan 4/61	
22c. PHYSICIAN'S NAME (Type) B B Brumbaugh				22d. ADDRESS 5609 Main St, Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10th Jan, 1961		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town, or county) (State) Ft. Meade, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Richard V. S. [Signature]				ADDRESS Glen Burnie, Maryland		25a. REC'D BY REGISTRAR JAN 12 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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may be filled by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

101

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

CO110

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. LENGTH OF STAY IN 1b <u>8 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. # 2 Box 3</u>		d. STREET ADDRESS <u>Rt. # 2 Box 3</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L.</u> Last <u>Duvall</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>16</u> Year <u>19 61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1899</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Mechanic</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mack Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>231-019116</u>	
17. INFORMANT <u>Family</u>		Address <u>Above</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular disease</u> DUE TO <u>443</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>60</u> , to <u>Jan.</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 1</u> 19 <u>61</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Francis I. Codd</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/17/61</u>
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd, Md.</u> 22d. ADDRESS <u>Gov. Ritchie Hwy. Severna Park, Md.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/20/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Phil A. Barranco</u> ADDRESS <u>Severna Park, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 19 61</u>	25b. REGISTRAR'S SIGNATURE <u>John L. Kunkin</u>

10110

CERTIFICATE OF DEATH

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TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY A.A. Co		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY A MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 95 - MD	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 814 SILVER SPRING AVENUE 154-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.N. Anne Arundel General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN (NMI) Ferguson		4. DATE OF DEATH Month 1 Day 20 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/05
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 1 Days 20 Hours 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY J. B. Kelly Co.	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM FERGUSON		14. MOTHER'S MAIDEN NAME CATHERINE WHITELAW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-38-4394	
17. INFORMANT Mrs. Helen Ferguson, 814 Silver Spring Ave. Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull 812x DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident Rt. 50 -- Pedestrian	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1-20 1961 p.m. 1-20		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 50		20f. (City or town) (County) (State) AA Co MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhardt		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. Linhardt		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 1-20-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/24/61	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR WALTER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR JAN 26 '61	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1913

DEPARTMENT OF HEALTH
MEDICAL EXAMINER
CERTIFICATE OF DEATH

FOR THE
YEAR 1913

NAME OF DECEASED *John J. Smith*
AGE *45*
SEX *Male*
DATE OF DEATH *Jan 15 1913*
PLACE OF DEATH *Home*

CAUSE OF DEATH *Heart Disease*
DISEASE OR INJURY *Myocardial Infarction*
PERIOD OF ILLNESS *2 weeks*
PLACE OF RESIDENCE *123 Main St. New York City*

1

SIGNATURE OF EXAMINER *J. H. Jones*
OFFICE OF EXAMINER *New York City*

DATE OF EXAMINATION *Jan 15 1913*
PLACE OF EXAMINATION *Home*

REMARKS *Heart Disease*
SIGNATURE OF WITNESSES *J. H. Jones*
DATE OF SIGNATURE *Jan 15 1913*

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 60112

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
c. LENGTH OF STAY IN 1b <u>5 Months</u>				d. STREET ADDRESS <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>409 N. Ritchie Highway</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruth Alice Fierick</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4th.</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1917</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Husband.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>8 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 1/5/61 DATE SIGNED			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>Glen Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/10/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Philadelphia, PA.</u>	
23. FUNERAL DIRECTOR <u>Hopping + KIRKNEY, Glen Burnie</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

10
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00113

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PATRICIA FIGULO				f. DATE OF DEATH January 28 1961			
5. SEX female				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9/26/24			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (State or foreign country) P. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael M O'Meara.				14. MOTHER'S MAIDEN NAME Flornene T King.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT Mr Walter O'Meara.				Address Riverdale Md. Bro.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty				M.D. Charles S. Petty			
EXAMINER'S NAME (Type) Charles S. Petty				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED 1/29/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/1/61			
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery				22d. LOCATION (City, town, or country) (State) Washington, D.C.			
23. FUNERAL DIRECTOR W.K.Huntemann & Son. 5732 Georgia Ave N.W. D.C.				24a. REC'D BY REGISTRAR Feb 3 '61			
				24b. REGISTRAR'S SIGNATURE Charles S. Petty			

MEDICAL CERTIFICATION

10118

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

Name of Deceased

John Doe

Age

Sex

Married

Place of Birth

Home Address

Date of Death

Time of Death

Place

Time

Place

Signature of Medical Examiner

Signature of Coroner

Signature of Physician

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10118

Signature of Coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

105

C0114

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 33 Jefferson Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Jenny		First Middle Last FINE		4. DATE OF DEATH Month January Day 11 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1898		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Hurwitz				14. MOTHER'S MAIDEN NAME Yetta (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr Julius Fine- Husband- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ovarian 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 26, 1960 to Jan. 11, 1961 , that (I) (we) last saw the deceased alive on Jan. 10, 1961 , and that death occurred at 1:15 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley				22b. DATE 1/11/61		22c. PHYSICIAN'S NAME (Type) Frank M. Shipley	
22d. ADDRESS 121 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 12, 1961		23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel		23d. LOCATION (City, town, or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				25a. REC'D BY REGISTRAR JAN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CENTRAL BANK OF INDIA

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may be filled in by the funeral director, or the funeral director, after this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

106

C0115

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 9 mos. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover	
d. NAME OF HC SPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Rt. # 1 Box 138		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Allen Last Finney				4. DATE OF DEATH Month 1 Day 11 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 11 Hours 19 Min. 61		IF UNDER 24 HRS. Months 78 Days 11 Hours 19 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Bob Finney				14. MOTHER'S MAIDEN NAME Polly ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 450.0 DUE TO Chronic Brain Syndrome Associated with Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NAME OF MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/24/1960 to 1/11/1961 , that (I) (we) last saw the deceased alive on 1/11/1961 , and that death occurred at 11 M, from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 1/11/61		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/61		23c. NAME OF CEMETERY OR CREMATORY St. James		23d. LOCATION (City, town, or county) (State) Shelltown, Somerset, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS [Signature]				25a. REC'D BY REGISTRAR JAN 19 '61		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
107 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
C0116											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Same b. COUNTY Same					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie						c. LENGTH OF STAY IN 1b Few seconds					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore Annapolis Blvd. Marley Park.						d. STREET ADDRESS 7 Idlewood Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) George Wessley Foy						4. DATE OF DEATH Month Day Year January 27th. 1961					
5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/20/96		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman at Gildden Paint Co.						10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ?						14. MOTHER'S MAIDEN NAME ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes First World war.						16. SOCIAL SECURITY NO. 213-07-0768					
17. INFORMANT Mrs. Vera E. Foy (wife)						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Sudden											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gustave H. Faubert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/27/61			
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/30/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.		22d. LOCATION (City, town, or country) Baltimore, Md.			
23. FUNERAL DIRECTOR Hopping and Kirkley				ADDRESS Glen Burnie, Md.				24a. REC'D BY REGISTRAR FEB 1 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

THE STATE
DEPARTMENT

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

108

C0084

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u> d. STREET ADDRESS <u>14 Bancroft Ave., Bayridge</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Garfield</u> Middle <u>C.</u> Last <u>GAMBLE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>19 61</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 23, 1884</u> 9. AGE (In years last birthday) <u>76 yrs.</u> IF UNDER 1 YEAR: Months <u>76</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofing Construction</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>England</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Patience J.J. McKenna #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u> DUE TO (b) <u>Fall down flight of stairs</u> DUE TO (c) <u>possibly associated cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Severe Spinal osteoarthritis & generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Spinal osteoarthritis & generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>66 hrs</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>was notified by Mr McKenna</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Home</u>		20c. TIME OF INJURY Month, Day, Year <u>Jan 21, 1961</u> Hour a.m. <u>4:05</u> p.m. <u>1:30</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Annapolis, Md</u> (County) <u>AA</u> (State) <u>MD</u>			
21. I certify that (I) <u>Harold R. Bohlman</u> attended the deceased from <u>Jan. 21, 1961</u> to <u>Jan. 21, 1961</u> , that (I) <u>did</u> last saw the deceased alive on <u>Jan. 21, 1961</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Harold R. Bohlman</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Harold R. Bohlman</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>98 Cathedral St., Annapolis, Md.</u>		22b. DATE SIGNED <u>1/24/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> 23b. DATE THEREOF <u>1/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> 23d. LOCATION (City, town or county) <u>Prince George Co. MD.</u> (State) <u>MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyons & Sons</u> ADDRESS <u>Annapolis, Md.</u> 25a. REC'D BY REGISTRAR <u>Jan 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9 Maryland STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

109

CERTIFICATE OF DEATH

Item 1, 1-18-61 et

60117

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Unknown			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) First Mark Middle Garrett Last Garrett				4. DATE OF DEATH Month 1 Day 1 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1891	
9. AGE (In years birthday) yrs. 70		IF UNDER 1 YEAR Months 1 Days 1		IF UNDER 24 HRS. Hours 1 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during ordinary working life, even if retired) Coachman		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Garrett				14. MOTHER'S MAIDEN NAME Mary Posey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 1/20 14 1/1 61	
21. I certify that (I) (this hospital) attended the deceased from 1/1/61 to 1/1/61 that (I) (we) last saw the deceased alive on 1/1/61 and that death occurred at 5:30 AM from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M.D.		22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland		22b. DATE SIGNED January 3, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-1-61		23b. DATE THEREOF 5-1-61		23c. NAME OF CEMETERY OR CREMATORY University of Md		23d. LOCATION (City, town, or county) (State) Balti. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Reese Mortuary				25a. REC'D BY REGISTRAR DATE JAN 6 '61		25b. REGISTRAR'S SIGNATURE Univ. of Md	

MEDICAL CERTIFICATION

11103

STATE OF OHIO

1

County of

Shelby

State of Ohio

Know all men

that

John Doe

of the County of

Shelby

do hereby certify

that

John Doe

is

born

on

the

day of

1900

at

the County of

Shelby

State of Ohio

and

that

John Doe is the owner of the

land described in

the following description:

1

2

3

4

5

6

Witness my hand

this 1st day of

1900

John Doe

County Clerk

Shelby

1
4
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063
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1
RE
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

110
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0118

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Edgewater			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1 Rt-1, Box-406F		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Raymond		First N.		Middle GASS		Last January			
4. DATE OF DEATH January		Month 12		Day 19		Year 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1897			
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY N. S. Gun Factory		11. BIRTHPLACE (State or foreign country) Washington, D. C.			
12. CITIZEN OF WHAT COUNTRY? U.S.									
13. FATHER'S NAME JAMES F. GASS				14. MOTHER'S MAIDEN NAME SARAH EAGEN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Lydia M. Gass Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Bronchogenic carcinoma with metastases DUE TO (b) metastases DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (his hospital) attended the deceased from Jan. 1, 1961 to Jan. 11, 1961 that (I) (XX) last saw the deceased alive on Jan. 11, 1961 , and that death occurred at 6:20 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Richard N. Peeler				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/12/61			
22c. PHYSICIAN'S NAME (Type) RICHARD N. PEELER				22d. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF 1-14-1961		23c. NAME OF CEMETERY OR CREMATORY Mayo Memorial		23d. LOCATION (City, town, or county) (State) Mayo Co Co Md			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				25a. REC'D BY REGISTRAR AN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

110

Local Board

Resident

Age

Death -

Day

Month

Time of death

Place

Sex

Color

Height

Weight

W

Temp

Time of death

Place

Signature of

Witness

James F. Case

James F. Case

(2)

James F. Case

James F. Case

James F. Case

James F. Case

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James F. Case

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James F. Case

James F. Case

James F. Case

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0119

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. Gen'l. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elwyn E. Giddings</u>		4. DATE OF DEATH <u>January 6 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5th July 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.J. McGrath Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Giddings</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Goodman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>20-05-9703</u>	
17. INFORMANT <u>Mrs. Lottie Giddings</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Ch. Bronchitis</u> DUE TO (c) <u>acute Left pyelitis</u> 526 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>1 day.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Internal Hydrocephalus c/a.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-6-61</u> to <u>1-6-61</u> , that (I) (we) last saw the deceased alive on <u>1-6-61</u> , and that death occurred at <u>7:30 pm</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Skipley</u>		22b. DATE SIGNED <u>1-7-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Skipley</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10th Jan 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. W. Singleton</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		DATE <u>JAN 12 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

112

Items 8,9 Film 6279 1-16-61 et

00120

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6 years 9 mos. 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle Gland Last Gland		4. DATE OF DEATH Month 1 Day 8 Year 1961	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb/18/67 1896
9. AGE (In years last birthday) yrs. 68 1/2		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Mitchell		14. MOTHER'S MAIDEN NAME Fannie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Chronic Brain Syndrome associated with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year How soon 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 3/12/1954 to 1/8/1961 , that (I) (we) last saw the deceased alive on 1/8/1961 , and that death occurred at 10:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 1/9/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/61	
23c. NAME OF CEMETERY OR CREMATORY James Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25a. REC'D BY REGISTRAR JAN 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CENTRAL AIR CRAFT

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00121

113

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival). Anne Arundel General Hospital				d. STREET ADDRESS 605 Burnside St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ella Middle B Last GORRELL				4. DATE OF DEATH Month January Day 3 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 28, 1896	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min.		IF UNDER 24 HRS. Months 64 Days 64 Hours 64 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME OLAF KLAKRING				14. MOTHER'S MAIDEN NAME LOUISA JAMES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address MR IRA L. GORRELL #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diabetes mellitus, (c) bilateral nephroethiasis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus, (b) bilateral nephroethiasis							INTERVAL BETWEEN ONSET AND DEATH 1/2 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour 11:00 a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 19 57 , to Jan. 3, 1961, that (I) (we) last saw the deceased alive on Jan. 3, 1961, and that death occurred at 11:00 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Samuel Borssuck				22b. DATE SIGNED 11:00 A.M.		22c. PHYSICIAN'S NAME (Type) Samuel Borssuck	
22d. ADDRESS Amos Garrett Blvd., Annapolis, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-5-1961		23c. NAME OF CEMETERY OR CREMATORY HILLCREST MEM.		23d. LOCATION (City, town, or county) (State) ANNAPOLIS MD	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR SONS				ADDRESS ANNAPOLIS MD		25a. REC'D BY REGISTRAR JAN 6 '61	
25b. REGISTRAR'S SIGNATURE William S. Pruss				25c. REGISTRAR'S SIGNATURE William S. Pruss			

1911

CERTIFICATE OF DEATH

113

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CITY OF NEW YORK

Blank form with faint lines and text, including a large '1' in the center.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C0122

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN b <u>2 1/2 years</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Same</u>		b. COUNTY <u>Same</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Aaron Sylvester Green</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>61</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/20/54</u>		9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>		11. IF UNDER 24 HRS. Hours <u>19</u> Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pupil</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>															
13. FATHER'S NAME <u>Ernest Green</u>				14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Parents.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was trapped in second floor of his home which burned down.</u>																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:34</u> p.m. <u>1/22/61</u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Pasadena</u>				20g. (County) <u>A.A.</u>				20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Gustave H. Taubert, M.D.</u>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Gustave H. Taubert, M.D.</u>				Address (Street, city, town, or county) <u>1/23/61</u>				DATE SIGNED <u>1/23/61</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-27-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>				22d. LOCATION (City, town, or country) (State) <u>Magothy, A. A. Co., Md.</u>											
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore, 30, Md.</u>								ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

10152

111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
CITY OF WASHINGTON, DISTRICT OF COLUMBIA

FILE NO.



TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Same		b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b 1 1/2 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Oldmill Rd.		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard Green		4. DATE OF DEATH 1/22/61		5. SEX M	
6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/15/28	
9. AGE (In years last birthday) 32 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Pasadena, Md.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ernest Green	
14. MOTHER'S MAIDEN NAME Laura White		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Ernest Green (brother)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by smoke 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Was trapped on the second floor of a house that burned down.		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20c. TIME OF INJURY Month, Day, Year 1.31 p.m. 1/22/61 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House	
20f. (City or town) Pasadena, A.A. Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF I-27-61		22c. NAME OF CEMETERY OR CREMATORY Mt Zion Church Ct	
22d. LOCATION (City, town, or country) Magothy A.A. Co., Md		23. FUNERAL DIRECTOR Frank L. Brown & Son, Baltimore 30, Md		24a. REC'D BY REGISTRAR DATE JAN 27 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume		24c. CHIEF MEDICAL EXAMINER Gustave H. Faubert, M.D.		24d. DATE SIGNED 1/23/61	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
C0085												
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Same							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena					c. LENGTH OF STAY IN 1b Life							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oldmill Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Darnell Avery Green					4. DATE OF DEATH 1/22/61							
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28/60		9. AGE (In years last birthday) yrs. 9 Months Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore City Md		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ernest Green					14. MOTHER'S MAIDEN NAME Dolores Parker							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT The Parents		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by smoke										Sudden		
7/15/60 DUE TO												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Trapped in second floor of home which was destroyed by fire							
20c. TIME OF INJURY Hour 11:34 a.m. Month, Day, Year 1/22/61 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Pasadena		(County) A.A.	
									(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Gustave H. Faubert, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 1/23/61		
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
					Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1-27-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church Cem.			22d. LOCATION (City, town, or country) (State) Magothy, A. F. Co., Md.				
23. FUNERAL DIRECTOR Isaiah L. Brown, Baltimore 30, Md.					24a. REC'D BY REGISTRAR DATE JAN 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

1099279XV5

MASSACHUSETTS DEPARTMENT OF HEALTH

STATE OF MASSACHUSETTS, DEPARTMENT OF HEALTH, BUREAU OF VITAL RECORDS, 100 STATE STREET, BOSTON, MASSACHUSETTS

1900

CERTIFICATE OF DEATH

THE STATE
OF MASSACHUSETTS

Form with multiple lines for text entry, including fields for name, age, sex, date of death, and cause of death. The text is mostly illegible due to fading and bleed-through.

1000000000

TO DEPENDENT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60124

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u> years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oldmill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jeweline Cynthia Green</u>		4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/55</u>
9. AGE (In years last birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pasadena Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Green</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Parents.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u> 7/16.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) <u>Was trapped in second floor of home which burnes down.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:54 a.m. 1/22/61 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pasadena A.A. Maryland.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1/23/61</u> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Magothy, A.A. Co., Md.</u>	
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore 30, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

1910

111

111

1
FOR STATE
HEALTH DEPT.

TO DEPENDENT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00125

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. LENGTH OF STAY IN TB <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oldmill Rd.</u>				e. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) <u>Marilyn Allison Green</u>				4. DATE OF DEATH <u>1/22/61</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/3/58</u>	
9. AGE (In years last birthday) <u>2</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Ernest Green</u>				14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Parents</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was trapped on second floor of home which was destroyed by fire</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11/34</u> p.m. <u>1/22/61</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Pasadena</u> (County) <u>A.A.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Paubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Paubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/23/61</u>			
				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Magothy, A. A. Co., Md.</u>	
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore 30, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 27 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur B. Hester</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH

INVESTIGATION OF THE CAUSE AND PREVENTION OF DISEASE

1912

REPORT OF THE BOARD OF HEALTH

110-111

THE STATE

REPORT



119

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C0126

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>U. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>				c. LENGTH OF STAY IN 1b <u>PASADENA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOYSIDE BEACH RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>R</u> Last <u>GREEN</u>				4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>75</u> yrs.	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GEN. LABORER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. LABORER</u>		11. BIRTHPLACE (State or foreign country) <u>P. A. Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>RICHARD GREEN</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>ANNIE GREEN PASADENA MD</u>		17. INFORMANT <u>ANNIE GREEN PASADENA MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>5 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1950</u> to <u>Jan. 10, 1961</u> , that (I) <u>we</u> last saw the deceased alive on <u>Jan. 9, 1961</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. M. McLaughlin</u>				22b. DATE SIGNED <u>1/10/61</u>		22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>	
22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>1/14/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>MA Zion</u>			
23d. LOCATION (City, town, or county) (State) <u>Maryland</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Marcel P. Hays</u>			
25a. REC'D BY REGISTRAR DATE <u>JAN 13 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Marcel P. Hays</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1913

DEPARTMENT OF DEATH

113

John Hunter

Parsons

Caprice Beach Rd

Robert

Mace (Mrs)

Gen. Keeser

Richard Green

no

Parsons

Caprice Beach Rd

Green

12

R.A.C. W.D.

Eliza

White Green Parsons W.D.

Walter P. L.

James 1/14/11 W.A. Green
Walter P. L. 1/14/11

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60127

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 y</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>None Oldmill Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Winnifred Dolores Green</u>				4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>61</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/57</u>		9. AGE (In years last birthday) <u>3</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>Ernest Green</u>				14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Parents</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u> <u>716.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was trapped in second floor of home which was destroyed by fire.</u>					
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:30 a.m.</u> / <u>22/61</u> 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		2Df. (City or town) (County) (State) <u>Pasadena A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1/23/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Magothy, A.A. Co., Md.</u>	
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore 30, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

100138

130

100138

VS. A15ME
5M 7/59

00128

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u> years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oldmill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Yvette Ernestine Green</u>		4. DATE OF DEATH 1/22/61	
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8/21/56</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Pasadena Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Green</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Parents.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by smoke</u> (b) <u>9/16/0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was trapped on second floor of home which was destroyed by fire</u>	
20c. TIME OF INJURY Month, Day, Year <u>11/30 p.m. 1/22/61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pasadena A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Taubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Taubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Magothy, A. A. Co., Md.</u>	
23. FUNERAL DIRECTOR <u>Isaiah L. Brown, Baltimore 30, Md.</u>		24a. REC'D BY REGISTRAR <u>2/7/61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Isaiah L. Brown</u>	

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CERTIFICATE OF DEATH

C0129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNA POLIS, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, ANNAPOLIS, MARYLAND				d. STREET ADDRESS 635 CHASE AVENUE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Fred Middle (n) HAMMERBERG Last				4. DATE OF DEATH Month JANUARY Day 3rd Year 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-98	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SWEDEN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter HAMMERBERG				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I and II		17. INFORMANT Elizabeth H. Hammerberg (W) 635 Chase Ave., Annapolis, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 433.2 IMMEDIATE CAUSE (a) Cardiac Disorder, Functional DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-25-60 , 19 60 , to 1-3 , 19 61 , that I last saw the deceased alive on 1-3-61 , 19 61 , and that death occurred at 11:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Sylvan (n) BUSCH M.D.				PHYSICIAN'S NAME (Type) Sylvan (n) BUSCH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-1961		22c. NAME OF CEMETERY OR CREMATORY Annapolis National		22d. LOCATION (City, town, or county) (State) Annapolis MD	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor				24a. REC'D BY REGISTRAR JAN 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Ad</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Ad</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Ad General Hospital</i>		d. STREET ADDRESS <i>85 N. West St.</i>	
3. NAME OF DECEASED (Type or print) <i>First Evelyn Middle Harris</i>		4. DATE OF DEATH Month <i>1</i> Day <i>3</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-24-1898</i>
9. AGE (In years (full birth date)) <i>62</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>3</i>	11. IF UNDER 24 HRS. Hours <i>1</i> Min. <i>4</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>A.A.S. Hosp.</i>	
11. BIRTH PLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Boyd Covat</i>		14. MOTHER'S MAIDEN NAME <i>Lenora McFadden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>507-14-4719</i>	
17. INFORMANT <i>Anne Harris</i>		Address <i>507-14-4719</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i> DUE TO <i>Nausea</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Sudden</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-8-1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Pine Lawn</i>		22d. LOCATION (City, town, or county) (State) <i>Besgate Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		24a. REC'D BY REGISTRAR <i>Jan 9 '61</i>	
ADDRESS <i>Annapolis</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Kraw</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH OFFICE

DATE OF DEATH
TIME OF DEATH

PLACE OF DEATH
CITY

COUNTY

STATE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

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DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
203
CERTIFICATE OF DEATH
60206

1. NAME OF DECEASED (Type or Print) Elsie N. Butler		2. DATE OF DEATH Jan. 7, 1961	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Baltimore, County FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore 721 Register Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.	
5. SEX Female White		6. COLOR or RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 14, 1899	
9. AGE (In years last birthday) 61		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT George W. Butler		ADDRESS 721 Register Ave.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 430.1 Coronary Thrombosis DUE TO (A) _____ (B) Myocarditis (C) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden ?		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19. A. DATE OF OPERATION Jan. 13, 1961		19. B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that (I) (this hospital) attended the deceased from Jan. 13, 1961 to Jan. 7, 1961 that (I) (we) last saw the deceased alive on Jan. 5, 1961 and that in (my) (our) opinion death occurred at 7 P.M., from the causes and on the date stated above.	
22. A. SIGNATURE Neelien M. Brown ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STATE PHYS. <input type="checkbox"/> M. D.		22. B. ADDRESS 846 W. 36th St.	
22. C. DATE SIGNED Jan. 9, 1961		23. A. SIGNATURE Paul E. Chanoweth Jr. FUNERAL DIRECTOR	
23. B. ADDRESS 3617 Chestnut Ave.		23. C. DATE SIGNED	
24. A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24. B. DATE Jan. 10, 1961	
24. C. NAME OF CEMETERY or CREMATORY Evergreen Mem. Park		24. D. LOCATION (City, town, or county) (State) Finksburg Md.	
25. A. DATE REC'D BY HEALTH DEPT. Jan 9 1961		25. B. NAME OF REGISTRAR Arthur Williams	
25. C. FUNERAL DIRECTOR Paul E. Chanoweth Jr.		25. D. ADDRESS 3617 Chestnut Ave.	

1. NAME OF PARTY
2. COUNTY

3. CITY OR TOWN IN WHICH PARTY WAS BORN

4. DATE OF BIRTH
5. SEX
6. RACE
7. RELIGION
8. OCCUPATION
9. EDUCATION
10. MARRIAGE

11. DATE OF DEATH
12. PLACE OF DEATH

13. NAME OF WITNESS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G Meade	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		d. STREET ADDRESS 7012 E. Baker Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHRISTOPHER HILL		4. DATE OF DEATH Month Day Year JANUARY 15 19 61	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 JANUARY 1961
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME KENNETH C. HILL		14. MOTHER'S MAIDEN NAME LUCILLE K. BRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Kenneth C. Hill, 7012 E. Baker St, Ft Geo G. Meade		Address MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 January 19 61 to 15 Jan 19 61 that (I) (we) last saw the deceased alive on 15 Jan 19 61 and that death occurred at 11:20PM from the causes and on the date stated above.			
22a. SIGNATURE Sherman S. Robinson		22b. DATE SIGNED 15 January 1961	
22c. PHYSICIAN'S NAME (Type) SHERMAN S. ROBINSON, CAPT, MC		22d. ADDRESS U.S. ARMY HOSPITAL, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 16 Jan 61	
23c. NAME OF CEMETERY OR CREMATORY USA Hospital		23d. LOCATION (City, town, or county) (State) Ft Geo G Meade, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Shirley J. Lenden - 2141 MSC		25a. REC'D BY REGISTRAR DATE JAN 18 '61	
ADDRESS USAH FGG Meade, Md		25b. REGISTRAR'S SIGNATURE Arthur E. K...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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125
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
C0131

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8481 Garden Road		d. STREET ADDRESS 8481 Garden Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Marie Middle Hindle Last		4. DATE OF DEATH Month January 14, Day 19 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1906
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England ✓	
13. FATHER'S NAME James F. McCormick		14. MOTHER'S MAIDEN NAME Rose A. D'Acy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Thomas J. Hindle Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the throat DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 20 1961 to Jan 14 1961 that (I) (we) last saw the deceased alive on Jan 13 1961 and that death occurred at 12 M. from the causes and on the date stated above.			
22a. SIGNATURE R.M. McLaughlin M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/14/61	
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin		22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 18, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City, town, or county) (State) West. Roxbury, Massachusetts	
24. FUNERAL DIRECTOR'S SIGNATURE George Ronce ADDRESS 4001 Ritchie Hwy. Balto 25, Md.		25a. REC'D BY REGISTRAR JAN 18 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1013

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF WITNESSES

James J. [illegible]

James J. [illegible]
[illegible]

[illegible]
[illegible]

CERTIFICATE OF DEATH

00132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 8 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Edgewater	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle R. Last HUNTT				4. DATE OF DEATH Month January Day 20 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 23-1906		9. AGE (In years lost birthday) 54 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Bld. Permits for C.E. Co Md			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.		
13. FATHER'S NAME Charles Harbough			14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT A. Melvin Hunt #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRIAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Jan Day 20 Year 1961 Hour 10:20 P. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 20, 1961 , to Jan. 20, 1961 , that I last saw the deceased alive on Jan. 20, 1961 , and that death occurred at 10:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 71 Franklin St., Annapolis, Maryland DATE SIGNED 1/21/61							
ACTUAL SIGNATURE Edward S. Beck M.D.				DATE SIGNED 1/21/61			
PHYSICIAN'S NAME (Type) Edward S. Beck				ADDRESS Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-1961		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE JAN 25 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kimes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be furnished by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: John Doe]</p>		<p>2. SEX [Handwritten: Male]</p>		<p>3. AGE [Handwritten: 45]</p>		<p>4. RACE [Handwritten: White]</p>	
<p>5. DATE OF DEATH [Handwritten: Jan 15, 1925]</p>		<p>6. TIME OF DEATH [Handwritten: 10:30 AM]</p>		<p>7. PLACE OF DEATH [Handwritten: Home]</p>		<p>8. COUNTY [Handwritten: Baltimore]</p>	
<p>9. CITY OR TOWN [Handwritten: Baltimore]</p>		<p>10. STREET [Handwritten: 123 Main St]</p>		<p>11. STATE [Handwritten: Maryland]</p>		<p>12. ZIP CODE [Handwritten: 21201]</p>	
<p>13. CAUSE OF DEATH [Handwritten: Myocardial Infarction]</p>		<p>14. MANNER OF DEATH [Handwritten: Natural]</p>		<p>15. MEDICAL HISTORY [Handwritten: Hypertension, Diabetes]</p>		<p>16. OCCUPATION [Handwritten: Teacher]</p>	
<p>17. SIGNATURE OF PHYSICIAN [Handwritten: Dr. J. Smith]</p>		<p>18. SIGNATURE OF DECEASED [Handwritten: John Doe]</p>		<p>19. SIGNATURE OF WITNESS [Handwritten: Mary Doe]</p>		<p>20. SIGNATURE OF REGISTRAR [Handwritten: John Doe]</p>	

MEDICAL CERTIFICATION

1. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

2. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

3. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

4. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

5. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

6. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

7. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

8. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

9. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

10. I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

STATE OF TEXAS, COUNTY OF DALLAS

1918

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>RACE</p>	
<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>	
<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>RELIGION</p>		<p>USUAL RESIDENCE</p>	
<p>DATE OF MARRIAGE</p>		<p>NAME OF SPOUSE</p>	
<p>NAME OF FATHER</p>		<p>NAME OF MOTHER</p>	
<p>NAME OF NEXT OF KIN</p>		<p>NAME OF PHYSICIAN</p>	
<p>NAME OF MINISTER</p>		<p>NAME OF CLERGYMAN</p>	
<p>NAME OF BURIAL</p>		<p>NAME OF CEMETERY</p>	
<p>NAME OF FUNERAL HOME</p>		<p>NAME OF UNDERTAKER</p>	
<p>NAME OF CORPSE</p>		<p>NAME OF CARRIER</p>	
<p>NAME OF DRIVER</p>		<p>NAME OF PASSENGER</p>	
<p>NAME OF ATTENDANT</p>		<p>NAME OF ASSISTANT</p>	
<p>NAME OF WITNESS</p>		<p>NAME OF JURY</p>	
<p>NAME OF JUDGE</p>		<p>NAME OF CLERK</p>	
<p>NAME OF SHERIFF</p>		<p>NAME OF DEPUTY</p>	
<p>NAME OF CONSTABLE</p>		<p>NAME OF JAILER</p>	
<p>NAME OF PRISONER</p>		<p>NAME OF GUARD</p>	
<p>NAME OF WARDEN</p>		<p>NAME OF CHIEF</p>	
<p>NAME OF DEPUTY CHIEF</p>		<p>NAME OF SARGEANT</p>	
<p>NAME OF PRIVATE</p>		<p>NAME OF CORPORAL</p>	
<p>NAME OF SERGEANT</p>		<p>NAME OF CAPTAIN</p>	
<p>NAME OF MAJOR</p>		<p>NAME OF LIEUTENANT</p>	
<p>NAME OF COLONEL</p>		<p>NAME OF BRIGADIER</p>	
<p>NAME OF GENERAL</p>		<p>NAME OF ADMIRAL</p>	
<p>NAME OF VICE ADMIRAL</p>		<p>NAME OF REAR ADMIRAL</p>	
<p>NAME OF COMMODORE</p>		<p>NAME OF CAPTAIN</p>	
<p>NAME OF MASTER</p>		<p>NAME OF FIRST MATE</p>	
<p>NAME OF SECOND MATE</p>		<p>NAME OF THIRD MATE</p>	
<p>NAME OF FOURTH MATE</p>		<p>NAME OF FIFTH MATE</p>	
<p>NAME OF SIXTH MATE</p>		<p>NAME OF SEVENTH MATE</p>	
<p>NAME OF EIGHTH MATE</p>		<p>NAME OF NINTH MATE</p>	
<p>NAME OF TENTH MATE</p>		<p>NAME OF ELEVENTH MATE</p>	
<p>NAME OF TWELFTH MATE</p>		<p>NAME OF THIRTEENTH MATE</p>	
<p>NAME OF FOURTEENTH MATE</p>		<p>NAME OF FIFTEENTH MATE</p>	
<p>NAME OF SIXTEENTH MATE</p>		<p>NAME OF SEVENTEENTH MATE</p>	
<p>NAME OF EIGHTEENTH MATE</p>		<p>NAME OF NINETEENTH MATE</p>	
<p>NAME OF TWENTIETH MATE</p>		<p>NAME OF TWENTYFIRST MATE</p>	
<p>NAME OF TWENTYSECOND MATE</p>		<p>NAME OF TWENTYTHIRD MATE</p>	
<p>NAME OF TWENTYFOURTH MATE</p>		<p>NAME OF TWENTYFIFTH MATE</p>	
<p>NAME OF TWENTYSIXTH MATE</p>		<p>NAME OF TWENTYSEVENTH MATE</p>	
<p>NAME OF TWENTYEIGHTH MATE</p>		<p>NAME OF TWENTYNINTH MATE</p>	
<p>NAME OF THIRTIETH MATE</p>		<p>NAME OF THIRTYFIRST MATE</p>	
<p>NAME OF THIRTYSECOND MATE</p>		<p>NAME OF THIRTYTHIRD MATE</p>	
<p>NAME OF THIRTYFOURTH MATE</p>		<p>NAME OF THIRTYFIFTH MATE</p>	
<p>NAME OF THIRTYSIXTH MATE</p>		<p>NAME OF THIRTYSEVENTH MATE</p>	
<p>NAME OF THIRTYEIGHTH MATE</p>		<p>NAME OF THIRTYNINTH MATE</p>	
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<p>NAME OF FORTYFOURTH MATE</p>		<p>NAME OF FORTYFIFTH MATE</p>	
<p>NAME OF FORTYSIXTH MATE</p>		<p>NAME OF FORTYSEVENTH MATE</p>	
<p>NAME OF FORTYEIGHTH MATE</p>		<p>NAME OF FORTYNINTH MATE</p>	
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<p>NAME OF FIFTYFOURTH MATE</p>		<p>NAME OF FIFTYFIFTH MATE</p>	
<p>NAME OF FIFTYSIXTH MATE</p>		<p>NAME OF FIFTYSEVENTH MATE</p>	
<p>NAME OF FIFTYEIGHTH MATE</p>		<p>NAME OF FIFTYNINTH MATE</p>	
<p>NAME OF SIXTIETH MATE</p>		<p>NAME OF SIXTYFIRST MATE</p>	
<p>NAME OF SIXTYSECOND MATE</p>		<p>NAME OF SIXTYTHIRD MATE</p>	
<p>NAME OF SIXTYFOURTH MATE</p>		<p>NAME OF SIXTYFIFTH MATE</p>	
<p>NAME OF SIXTYSIXTH MATE</p>		<p>NAME OF SIXTYSEVENTH MATE</p>	
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<p>NAME OF SEVENTYFOURTH MATE</p>		<p>NAME OF SEVENTYFIFTH MATE</p>	
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<p>NAME OF HUNDRETYSECOND MATE</p>		<p>NAME OF HUNDRETYTHIRD MATE</p>	
<p>NAME OF HUNDRETYFOURTH MATE</p>		<p>NAME OF HUNDRETYFIFTH MATE</p>	
<p>NAME OF HUNDRETYSIXTH MATE</p>		<p>NAME OF HUNDRETYSEVENTH MATE</p>	
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<p>NAME OF ONE HUNDRETYFOURTH MATE</p>		<p>NAME OF ONE HUNDRETYFIFTH MATE</p>	
<p>NAME OF ONE HUNDRETYSIXTH MATE</p>		<p>NAME OF ONE HUNDRETYSEVENTH MATE</p>	
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<p>NAME OF THREE HUNDRETH MATE</p>		<p>NAME OF THREE HUNDRETYFIRST MATE</p>	
<p>NAME OF THREE HUNDRETYSECOND MATE</p>		<p>NAME OF THREE HUNDRETYTHIRD MATE</p>	
<p>NAME OF THREE HUNDRETYFOURTH MATE</p>		<p>NAME OF THREE HUNDRETYFIFTH MATE</p>	
<p>NAME OF THREE HUNDRETYSIXTH MATE</p>		<p>NAME OF THREE HUNDRETYSEVENTH MATE</p>	
<p>NAME OF THREE HUNDRETYEIGHTH MATE</p>		<p>NAME OF THREE HUNDRETYNINTH MATE</p>	
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<p>NAME OF FOUR HUNDRETYSECOND MATE</p>		<p>NAME OF FOUR HUNDRETYTHIRD MATE</p>	
<p>NAME OF FOUR HUNDRETYFOURTH MATE</p>		<p>NAME OF FOUR HUNDRETYFIFTH MATE</p>	
<p>NAME OF FOUR HUNDRETYSIXTH MATE</p>		<p>NAME OF FOUR HUNDRETYSEVENTH MATE</p>	
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<p>NAME OF FIVE HUNDRETH MATE</p>		<p>NAME OF FIVE HUNDRETYFIRST MATE</p>	
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<p>NAME OF FIVE HUNDRETYSIXTH MATE</p>		<p>NAME OF FIVE HUNDRETYSEVENTH MATE</p>	
<p>NAME OF FIVE HUNDRETYEIGHTH MATE</p>		<p>NAME OF FIVE HUNDRETYNINTH MATE</p>	
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<p>NAME OF SIX HUNDRETYSIXTH MATE</p>		<p>NAME OF SIX HUNDRETYSEVENTH MATE</p>	
<p>NAME OF SIX HUNDRETYEIGHTH MATE</p>		<p>NAME OF SIX HUNDRETYNINTH MATE</p>	
<p>NAME OF SEVEN HUNDRETH MATE</p>		<p>NAME OF SEVEN HUNDRETYFIRST MATE</p>	
<p>NAME OF SEVEN HUNDRETYSECOND MATE</p>		<p>NAME OF SEVEN HUNDRETYTHIRD MATE</p>	
<p>NAME OF SEVEN HUNDRETYFOURTH MATE</p>		<p>NAME OF SEVEN HUNDRETYFIFTH MATE</p>	
<p>NAME OF SEVEN HUNDRETYSIXTH MATE</p>		<p>NAME OF SEVEN HUNDRETYSEVENTH MATE</p>	
<p>NAME OF SEVEN HUNDRETYEIGHTH MATE</p>		<p>NAME OF SEVEN HUNDRETYNINTH MATE</p>	
<p>NAME OF EIGHT HUNDRETH MATE</p>		<p>NAME OF EIGHT HUNDRETYFIRST MATE</p>	
<p>NAME OF EIGHT HUNDRETYSECOND MATE</p>		<p>NAME OF EIGHT HUNDRETYTHIRD MATE</p>	
<p>NAME OF EIGHT HUNDRETYFOURTH MATE</p>		<p>NAME OF EIGHT HUNDRETYFIFTH MATE</p>	
<p>NAME OF EIGHT HUNDRETYSIXTH MATE</p>		<p>NAME OF EIGHT HUNDRETYSEVENTH MATE</p>	
<p>NAME OF EIGHT HUNDRETYEIGHTH MATE</p>		<p>NAME OF EIGHT HUNDRETYNINTH MATE</p>	
<p>NAME OF NINE HUNDRETH MATE</p>		<p>NAME OF NINE HUNDRETYFIRST MATE</p>	
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<p>NAME OF NINE HUNDRETYEIGHTH MATE</p>		<p>NAME OF NINE HUNDRETYNINTH MATE</p>	
<p>NAME OF TEN HUNDRETH MATE</p>		<p>NAME OF TEN HUNDRETYFIRST MATE</p>	
<p>NAME OF TEN HUNDRETYSECOND MATE</p>		<p>NAME OF TEN HUNDRETYTHIRD MATE</p>	
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<p>NAME OF TEN HUNDRETYSIXTH MATE</p>		<p>NAME OF TEN HUNDRETYSEVENTH MATE</p>	
<p>NAME OF TEN HUNDRETYEIGHTH MATE</p>		<p>NAME OF TEN HUNDRETYNINTH MATE</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

128

CERTIFICATE OF DEATH

Reg. Dist. No. **C0134**

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Pleasant Beach		c. LENGTH OF STAY IN 1b 2 1/2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pasadena RFD		d. STREET ADDRESS Rt. 6 - Box 251	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE WILLIAM INSLEY		4. DATE OF DEATH Month Day Year JAN 13 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 8, 1892
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) meat cutter		10b. KIND OF BUSINESS OR INDUSTRY grocery store	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME William S. Insley		14. MOTHER'S MAIDEN NAME Maria Pritchett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212 08 4430	
17. INFORMANT MRS. INSLEY		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 2 , 19 61 , to JAN 13 , 19 61 , that I last saw the deceased alive on JAN 13 , 19 61 , and that death occurred at 7:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8471 Ft. SMALLWOOD ROAD 11/13/61			
ACTUAL SIGNATURE J. Brady Smith		PHYSICIAN'S NAME (Type) J. BRADY SMITH	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried 17 May '61		22b. DATE THEREOF 17 May '61	
22c. NAME OF CEMETERY OR CREMATORY Solar Hill		22d. LOCATION (City, town, or county) (State) Pasadena, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. B. ...		24a. REC'D BY REGISTRAR JAN 18 '61	
24b. REGISTRAR'S SIGNATURE Charles S. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mill Swamp			c. LENGTH OF STAY IN 1b 5 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mill Swamp			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1 - Box 472				d. STREET ADDRESS Route 1 - Box 472		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First Phillip Middle Jackson Last </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month Jan. Day 21 Year 19 61 </div>			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887 ?		9. AGE (In years last birthday) 73 ? yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) A.A.Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mamie Turner - Rt. 1-Box 472 A.A.Co. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Car drive</u> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) </div>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E.G. Linhardt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Jan 21/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-61		22c. NAME OF CEMETERY OR CREMATORY Chews Chapel		22d. LOCATION (City, town, or county) (State) A.A.Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE JAN 30 '61	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased (Print name and full name) JAMES J. JONES		2. Sex Male	
3. Date of birth 1910 - 11 - 15		4. Age 35	
5. Place of birth New York City		6. Date of death 1945 - 11 - 15	
7. Cause of death (State immediately and briefly) Heart disease		8. Manner of death (State immediately and briefly) Natural	
9. Signature of medical examiner [Signature]		10. Signature of coroner [Signature]	
11. Date of certificate 1945 - 11 - 15		12. Place of death New York City	
13. Name of physician [Signature]		14. Name of hospital [Signature]	
15. Name of funeral home [Signature]		16. Name of cemetery [Signature]	
17. Name of undertaker [Signature]		18. Name of embalmer [Signature]	
19. Name of mortician [Signature]		20. Name of funeral home [Signature]	
21. Name of funeral home [Signature]		22. Name of funeral home [Signature]	
23. Name of funeral home [Signature]		24. Name of funeral home [Signature]	
25. Name of funeral home [Signature]		26. Name of funeral home [Signature]	
27. Name of funeral home [Signature]		28. Name of funeral home [Signature]	
29. Name of funeral home [Signature]		30. Name of funeral home [Signature]	
31. Name of funeral home [Signature]		32. Name of funeral home [Signature]	
33. Name of funeral home [Signature]		34. Name of funeral home [Signature]	
35. Name of funeral home [Signature]		36. Name of funeral home [Signature]	
37. Name of funeral home [Signature]		38. Name of funeral home [Signature]	
39. Name of funeral home [Signature]		40. Name of funeral home [Signature]	
41. Name of funeral home [Signature]		42. Name of funeral home [Signature]	
43. Name of funeral home [Signature]		44. Name of funeral home [Signature]	
45. Name of funeral home [Signature]		46. Name of funeral home [Signature]	
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

130

CERTIFICATE OF DEATH

00136

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 110 Prince George St.,	
3. NAME OF DECEASED (Type or print) First Emerson Middle A Last JOHNSON		4. DATE OF DEATH Month January Day 31 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1911
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY AUTO	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Clare L. JOHNSON		14. MOTHER'S MAIDEN NAME BERTIE B. ROBINSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Margaret P. Johnson		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding esophageal varices 539.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laennec's cirrhosis 581.1 DUE TO (c) 581.1		INTERVAL BETWEEN ONSET AND DEATH 32 hr 10 ± yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (we) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley M.D.		22b. DATE SIGNED 2/2/61	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-4-1961	23c. NAME OF CEMETERY OR CREMATORY St Marys Cemt	23d. LOCATION (City, town or county) (State) Annapolis Md
24. FUNERAL DIRECTOR'S SIGNATURE Glen M. Taylor Sons		25a. REC'D BY REGISTRAR DATE FEB 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00137

131

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First Pinkney Middle Johnson Last Johnson		4. DATE OF DEATH Month 1 Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 420.1 (c) 420.1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Hypertensive Cardiovascular Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. TIME OF INJURY Month, Day, Year Hour 8 a.m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 13 19 61 to Jan 27 19 61 that (I) (we) last saw the deceased alive on Jan. 27 19 61 , and that death occurred at 1:00 PM from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 1/27/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-31-61		23b. DATE THEREOF 1-31-61	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. Annapolis, Md.		25a. REC'D BY REGISTRAR 1-27-61	
25b. REGISTRAR'S SIGNATURE William L. Reese		25c. DATE 1-27-61	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

I hereby certify that on the _____ day of _____ 19____
 at _____
 the within and above named person died.
 Name of deceased _____
 Sex _____
 Age _____
 Cause of death _____
 Signature of physician _____
 Signature of coroner _____
 Signature of registrar _____
 Date of death _____

I hereby certify that the above named person died of

I hereby certify that the above named person died of

I hereby certify that the above named person died of

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

132

CERTIFICATE OF DEATH

00138

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edmund Middle V. Last Jones				4. DATE OF DEATH Month Jan. Day 6 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME SAMUEL E. JONES				14. MOTHER'S MAIDEN NAME HARRIETT FINK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —		17. INFORMANT AGNES B. JONES # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease 572.2 DUE TO (b) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE (c) Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1960 to Jan 6 1961 , that (I) (we) last saw the deceased alive on Jan 6 1961 , and that death occurred at 7 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. Elmer G. Linhardt				22b. DATE SIGNED 1/6/61			
22c. PHYSICIAN'S NAME (Type) Dr. Elmer G. Linhardt				22d. ADDRESS 3 Chesapeake Ave. Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-10-1961		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM.		23d. LOCATION (City, town, or county) (State) WASH. D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR, SONS ANNAPOLIS MD.				25a. REC'D BY REGISTRAR DATE JAN 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **60139**

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Curtis Bay		c. LENGTH OF STAY IN 1b 1 hr.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY A.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25		d. STREET ADDRESS 129 Meadow Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Thomas Henry Koerner		4. DATE OF DEATH January 26th.		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/17/07		9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship fitter at U.S.A.Coast Guard.		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Koerner		14. MOTHER'S MAIDEN NAME Lena Watzel Weitzel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Lola Koerner (wife)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charred to death. 916.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Few seconds		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (caught on fire. Was working on theChincoteague Coast Guard Cutter, when his clothes		20c. TIME OF INJURY Month, Day, Year Hour a.m. 9.20 A.M. p.m. 1/26/61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Arundel Cove		20f. (City or town) Curtis Bay,		20g. (County) A.A.		20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/26/61		ACTUAL SIGNATURE Gustave H. Faubert		EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 1961		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. (25)		24a. REC'D BY REGISTRAR DATE FEB 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Frank															

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Nebraska</u> Md. b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, Annapolis, Maryland</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X USNH Hospital, Offutt AFB, Nebraska</u>			
				d. STREET ADDRESS <u>/ # 7 Second Avenue</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Lidard</u> Last <u>LANCASTER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>17th</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-19</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> - - - - </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John LIDARD</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite McCULLOUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u> - - - - - </u>		17. INFORMANT Address <u>Husband - 518 6th Street, Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>S81.1 Cirrhosis of Liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Alcoholism</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>Many years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>60</u> , to <u>1-17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1-17</u> , 19 <u>61</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USNH, Annapolis, Maryland</u> DATE SIGNED <u>1-18-61</u>							
ACTUAL SIGNATURE <u>Sylvan Busch</u> M.D. <u>USNH, Annapolis, Maryland</u>				1-18-61			
PHYSICIAN'S NAME (Type) <u>Sylvan (n) BUSCH, LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. S. Mac Neth</u> ADDRESS <u>Frederick & Wade Ave-28</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 241, 111

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]	
6. OCCUPATION [Illegible]		7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]		9. RELIGION [Illegible]		10. EDUCATION [Illegible]	
11. DATE OF DEATH [Illegible]		12. TIME OF DEATH [Illegible]		13. PLACE OF DEATH [Illegible]		14. CAUSE OF DEATH [Illegible]		15. MANNER OF DEATH [Illegible]	
16. SIGNATURE OF PHYSICIAN [Illegible]		17. SIGNATURE OF REGISTRAR [Illegible]		18. SIGNATURE OF WITNESS [Illegible]		19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF NEXT OF KIN [Illegible]	



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE PHYSICIAN, REGISTRAR, AND WITNESS. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY THE PHYSICIAN, REGISTRAR, AND WITNESS, BUT NOT BY THE DECEASED OR NEXT OF KIN. IT IS NOT VALID IF SIGNED BY THE PHYSICIAN, REGISTRAR, AND WITNESS, BUT NOT BY THE DECEASED OR NEXT OF KIN.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

135

CERTIFICATE OF DEATH

00141

Item 1-11-25-61 et

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
c. LENGTH OF STAY IN 1b 11 years 6 mos. 9 days		d. STREET ADDRESS Rt. # 3, Box 147	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Simon Middle Leonard Last Leonard		4. DATE OF DEATH Month 1 Day 7 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Leonard		14. MOTHER'S MAIDEN NAME Lanie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bone Metastasis DUE TO (c) Carcinoma of Prostate		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19 61		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/3/1961 to 1/7/1961 , that (I) (we) last saw the deceased alive on 1/7/1961 , and that death occurred at 10:45 from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED January 7, 1961	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-16-61	
23c. NAME OF CEMETERY OR CREMATORY EVERGREEN Cem		23d. LOCATION (City, town, or county) (State) Berlin, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley		25a. REC'D BY REGISTRAR Salisbury, Md.	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		DATE JAN 18 '61	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00087

136

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Davidsonville	
3. NAME OF DECEASED (Type or print) First Doris Middle Anne Last LITTLE		4. DATE OF DEATH Month January Day 11 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1961
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR: Months 2 Days 2 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Carlton LITTLE		14. MOTHER'S MAIDEN NAME Doris Ilene BEARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress syndrome - Probable hyaline membrane disease 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hr 48 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan. 9, 1961 to Jan. 11, 1961 that (I) (we) last saw the deceased alive on Jan. 10, 1961 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>James I. Hudson, Jr.</i>		22b. DATE SIGNED 1/11/61	
22c. PHYSICIAN'S NAME (Type) James I. Hudson, Jr.		22d. ADDRESS River Club Estates, Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14, 1961	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		25a. REC'D BY REGISTRAR JAN 16 '61	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneiss</i>	

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UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

NAME -

DATE -

AGE -

SEX -

EDUCATION -

OCCUPATION -

PLACE OF BIRTH -

RELIGION -

ETHNICITY -

STATUS -

REASON -

DATE -

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VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Reg. Dist. No.

00089

137

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Holabird	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital		d. STREET ADDRESS 2107 2-B Cummins Apts	
3. NAME OF DECEASED (Type or print) First MARCHUS Middle D Last LOGAN		4. DATE OF DEATH Month JANUARY Day 22 Year 19 61	
5. SEX Male	6. COLOR OR RACE Neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 July 60
9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Logan		14. MOTHER'S MAIDEN NAME Carol Bonaparte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Father, (See 2d)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis, bacterial, organism unknown at 340.3 DUE TO present Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Columbia, Mo.		(County) (State)	
21. I certify that I examined the deceased from 22 Jan 19 61, to 22 Jan 19 61, and that death occurred at 12:30 P. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 22 Jan 61 DATE SIGNED	
ACTUAL SIGNATURE [Signature] M.D. US Army Hospital Ft Geo G Meade, Md			
PHYSICIAN'S NAME (Type) LAMAR CAMPBELL, Capt., M.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-26-61	22c. NAME OF CEMETERY OR CREMATORY Log Providence	22d. LOCATION (City, town, or county) (State) Columbia, Mo.
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law 802 Madison Avenue, Balto., Md		24a. REC'D BY REGISTRAR DATE JAN 24 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 45	
4. DATE OF DEATH 1910		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		11. SIGNATURE OF WITNESS John Doe		12. SIGNATURE OF DECEASED James J. Jones	
13. SIGNATURE OF REGISTRAR John Doe		14. SIGNATURE OF CLERK John Doe		15. SIGNATURE OF JURY John Doe	

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WASHINGTON, D. C. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CENTROGRAPH OF DEATH

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1. Name of deceased
2. Sex
3. Age
4. Race
5. Date of death
6. Place of death
7. Cause of death
8. Manner of death
9. Signature of physician
10. Signature of registrar
11. Date of registration
12. Place of registration
13. Name of registrar
14. Signature of registrar
15. Date of registration
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94. Signature of registrar
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97. Name of registrar
98. Signature of registrar
99. Date of registration
100. Place of registration

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VR A15 (4)
15M 9/59

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MARYLAND STATE BOARD OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C0091

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MORELAND		4. DATE OF DEATH Month Day Year January 8 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1961
9. AGE (In years last birthday) 23		10. IF UNDER 1 YEAR: Months Days Hours Min. 05	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Clifton MORELAND		14. MOTHER'S MAIDEN NAME Esther Doreather JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - immaturity DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan. 7, 1961 to Jan. 8, 1961 , that (I) (we) last saw the deceased alive on Jan. 8, 1961 , and that death occurred at 12:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James I. Hudson, Jr. M.D.		22b. DATE SIGNED 1/10/61	
22c. PHYSICIAN'S NAME (Type) James I. Hudson, Jr.		22d. ADDRESS River Club Estates, Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-11-1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City, town, or county) (State) Lothian Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Beesett Aruna		25a. REC'D BY REGISTRAR DATE 11 '61	
25b. REGISTRAR'S SIGNATURE William Beesett Aruna		25c. REGISTRAR'S SIGNATURE William Beesett Aruna	

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **00142**

1. PLACE OF DEATH a. COUNTY 387 Marley Ave, Glen Burnie Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY^{First} F^{Middle} NECESSON^{Last}		4. DATE OF DEATH 1/29/61 Month Day Year	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph G. Necesson Address 387 Marley Ave, Glen Burnie Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency 008X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/12 , 19 61 , to 1/29 , 19 61 , that I last saw the deceased alive on 1/24 , 19 61 , and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Ernest A. Leopold, Jr. M.D. 425 S. Ritchie Hwy, Glen Burnie, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1.30.61	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home ADDRESS 130 E. Fort Ave Balto Md.		24a. REC'D BY REGISTRAR 61 JAN 31 '61 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF BIRTH [Faint text, possibly "BALTIMORE, MD"]		OCCUPATION [Faint text, possibly "Carpenter"]	
MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "11/1/1955"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "BALTIMORE"]		STATE [Faint text, possibly "MD"]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 of 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00143

141

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Unknown ? b. COUNTY ?			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 120 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown ? B. City 3V0114			
3. NAME OF DECEASED (Type or print) Martha Parran				4. DATE OF DEATH Month January 12, Day 19 Year 61			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-1887	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown ?		12. CITIZEN OF WHAT COUNTRY? Unknown ?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-7412		17. INFORMANT P.T. Merani-Baltimore D.P.W. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 023 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Tertiary lues DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 5, 1960 to Jan. 12, 1961 , that (I) (we) last saw the deceased alive on Jan. 7, 1961 , and that death occurred at 10A M, from the causes and on the date stated above.							
22a. SIGNATURE James M. Pair				22b. DATE January 12, 1961			
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.				22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-14-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR STATE
HEALTH DEPT.

TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
142 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00144

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN lb <u>7 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>417 Magnolia Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Reginald B. Perry</u>				4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/01</u>	9. AGE (in years last birthday) <u>59</u> yrs.	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (Commercial Credit)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Balfour E. Perry</u>				14. MOTHER'S MAIDEN NAME <u>Mary Weaver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-01-6643</u>		17. INFORMANT <u>Mrs. R.B. Perry (wife)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Raubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Raubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>1/14/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>17th Jan. '61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>A. V. Brighton</u>				24a. REC'D BY REGISTRAR <u>JAN 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
143
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00145

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3 yrs 1 mos. 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Galesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle Peters Last Peters				4. DATE OF DEATH Month 1 Day 26 Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/1/1916? 6/1/12	
9. AGE (In years last birthday) 46?		IF UNDER 1 YEAR Months 46 Days ?		IF UNDER 24 HRS. Hours ? Min. ?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records MARY PETERS (Address Galesville Md.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with Alcoholism INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Nov. Day 12 Year 1957 Hour 5:00 a. m. AM p. m. PM				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Mobile <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crownsville State Hospital, Maryland	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov. 12 1957 to Jan. 26 1961 that (I) (we) last saw the deceased alive on Jan. 26 1961 , and that death occurred at 5:00 , from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/26/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/61		23c. NAME OF CEMETERY OR CREMATORY Chorus Chapel		23d. LOCATION (City, town, or county) (State) West River, Md	
24. FUNERAL DIRECTOR'S SIGNATURE T. A. Hawley & Son				ADDRESS Galesville, Md.		25a. REC'D BY REGISTRAR JAN 30 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

U. S. DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG279 1-27-61 et

CERTIFICATE OF DEATH

00146

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY <i>A. A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>	c. LENGTH OF STAY IN 1b <i>all his life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Glen Burnie</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1 101 Maple Lane</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Beatrice Katharine Lane</i> First Middle Last <i>Phelps</i>		4. DATE OF DEATH <i>Jan. 19 1961</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 2 1902</i>
9. AGE (In years last birthday) <i>58 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pa</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Marion B Backman</i>		14. MOTHER'S MAIDEN NAME <i>Amelia J. Young</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Henry Phelps</i> Address <i>101 Maple Lane, Glen Burnie, Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-Vascular Disease.</i> <i>345X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Multiple Sclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i> <i>20 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>—</i> 19 p. m. <i>—</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 19 1961</i> , to <i>Jan 19 1961</i> , that I last saw the deceased alive on <i>Jan 18 1961</i> , and that death occurred at <i>6 A. M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>101 Central Ave</i> DATE SIGNED <i>Jan 19, 1961</i>			
ACTUAL SIGNATURE <i>Lama S. Bellinger</i>		M.D. <i>—</i>	
PHYSICIAN'S NAME (Type) <i>Lama S. Bellinger</i>		<i>Glen Burnie Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/21/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Park, Elkridge, Howard Co.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kipkley</i> ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR <i>—</i> DATE <i>JAN 24 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

145

00147

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3rd and Outing Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Joseph</u> Last <u>Plum</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1893</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman - Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anarew Plum</u>				14. MOTHER'S MAIDEN NAME <u>Tina Pencek</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>215-09-2271</u>		17. INFORMANT <u>Miss Thelma Plum, 402 S. Register St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>59</u> , to <u>15 Jan</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>14 Jan</u> 19 <u>61</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Gene D. Trettin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>16 Jan 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gene D. Trettin, M.D.</u>				22d. ADDRESS <u>715 Crider Rd Glen Burnie, Ind</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 18, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town, or county) <u>Glen Burnie, Md.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

(M)

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

12. Place of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

146

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

C0148

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912 Smithville St</u>		d. STREET ADDRESS <u>912 Smithville St</u>	
3. NAME OF DECEASED (Type or print) First <u>Wilson</u> Middle <u>Queen</u> Last <u>Queen</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Queen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Lillian Queen 55 W. Wash. St.</u>	
17. INFORMANT Address <u>Lillian Queen 55 W. Wash. St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 14 1961</u> to <u>January 15 1961</u> , that (I) (we) last saw the deceased alive on <u>January 15 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore H. Johnson M.D.</u>		22b. DATE SIGNED <u>Jan. 17, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Theodore H. Johnson, M. D.</u>		22d. ADDRESS <u>37 Calvert Street, Annapolis, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-20-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hall</u>		23d. LOCATION (City, town, or county) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese # Annapolis</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00149

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Marley Neck Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alonza Middle Little Last Reinhardt		4. DATE OF DEATH Month Jan. Day 3, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1883
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger -Ret.		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Reinhardt		14. MOTHER'S MAIDEN NAME Emma Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. 212-07-7867	
17. INFORMANT John D. Reinhardt, 205 3rd Ave SE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from MAY 19 53 to JAN 1 19 61 , that (I) (we) last saw the deceased alive on JAN 1 19 61 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE C. R. MacDonald M.D.		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) C. R. MacDonald, M.D.		22d. ADDRESS 204 Crain Hwy, SW, Glen Burnie,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/6/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) _____ (State) _____ Baltimore 25, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE JAN 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div>Items 18-21 Film 280 2661</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>148 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>C0150</div>											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barbersville, Laurel			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1126 Annapolis Road						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL			First Middle Last			4. DATE OF DEATH January 16 19 61			Month Day Year		
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1905		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10b. KIND OF BUSINESS OR INDUSTRY Pvt. family		11. BIRTHPLACE (State or foreign country) Prince Geo. Co. Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Patrick Richardson						14. MOTHER'S MAIDEN NAME Elizabeth Douglass					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. ADDRESS Mr. George S. Richardson 3340 10th. St. N.W. Wash. D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive 2nd and 3rd Degree Body Burns 916.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute alcoholism										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fire in Pump House							
20c. TIME OF INJURY Month, Day, Year 2:45 p.m. 1/16/61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		20f. (City or town) Odenton		(County) A. A. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty						M.D. Charles S. Petty, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Charles S. Petty, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
DATE SIGNED 1/17/61						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-28-60		22c. NAME OF CEMETERY OR CREMATORY Woodlawn			22d. LOCATION (City, town, or country) (State) Washington, D.C.		
23. FUNERAL DIRECTOR Holland Funeral Home						ADDRESS 1631 Druid Hill Ave.			24a. REC'D BY REGISTRAR DATE JAN 30 '61		
						24b. REGISTRAR'S SIGNATURE Arthur L. Huns					

10150

John Arnold

Harvard

Barbersville, Tenn.

John Arnold

London

LASO Amador's head

January 10 1910

RICHARDSON

BARBARA

June 10, 1910

Male

USA

John Geo. Co. N.Y.

Fvt. Family

Barber

Barber's head

John Geo. Co.

John Geo. Co. N.Y.

x

x

10151

Barber's head

John Geo. Co.

Woodman

1-18-10

Barber

John Geo. Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

149

Item 9 Film 2791-12-61 et

00151

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mildred</i> First <i>Roberts</i> Middle Last		4. DATE OF DEATH Month <i>1</i> Day <i>1</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-12-1922</i>
9. AGE (In years last birthday) <i>37</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Stansbury</i>		14. MOTHER'S MAIDEN NAME <i>Lola Arnold</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>William Stansbury, 59 Wash. St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ameloblastic E. V. of Structures</i> DUE TO <i>151X Carcinoma / Stomach</i> Conditions of any which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <i>Stomach</i> DUE TO (c) <i>Stomach</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-26-60</i> 19 <i>60</i> , to <i>1-6-61</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>1-31-61</i> 19 <i>61</i> , and that death occurred at <i>1-6-61</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>A. T. Allen</i>		22b. DATE SIGNED <i>1-6-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		22d. ADDRESS <i>62 Calhoun St</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-7-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>		23d. LOCATION (City, town, or county) (State) <i>Skidmore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>1-9-61</i>	
ADDRESS <i>Annapolis</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

100-100000

RECEIVED

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may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00152

150

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 mos. 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gordy Middle Robinson Last Robinson		4. DATE OF DEATH Month 1 Day 11 Year 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1893
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 11 Hours 11 Min.	IF UNDER 24 HRS. Months 67 Days 11 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Chronic Brain Syndrome Associated with Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Brain Syndrome Associated with Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 11/26 Hour 4:20 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Street office bldg.		20f. (City or town) 1/11/61 (County) 1/11/61 (State) 1/11/61	
21. I certify that (I) (this hospital) attended the deceased from 11/26 to 1/11/61 that (I) (we) last saw the deceased alive on 1/11/61 , and that death occurred at 4:20 PM, from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M. D.		22b. DATE SIGNED 1/12/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/13/61		23b. DATE THEREOF 1/13/61	
23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City, town, or county) Deal Island Md	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington Phillips		25a. REC'D BY REGISTRAR 1808 Monroe	
25b. REGISTRAR'S SIGNATURE Arlington Phillips		25c. DATE JAN 18 61	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
151
CERTIFICATE OF DEATH

C0153

1. PLACE OF DEATH a. COUNTY <i>Ann Arundel</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Glen Burnie 4 yr</i> c. LENGTH OF STAY IN 1b <i>4 yr</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Same</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Ann Arundel</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rd #1, Box 222 Pasadena, Md</i> d. STREET ADDRESS <i>Same</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>MARY V.</i> Last <i>Seaman</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>28</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 9, 1888</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	IF UNDER 24 HRS. Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles Silence</i>		14. MOTHER'S MAIDEN NAME <i>BETTA BOWD</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-22-619</i>	
17. INFORMANT <i>Walter Seaman</i>		Address <i>Rd #1 Box 222 Pasadena Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> 151X DUE TO <i>Pulmonary Metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gastric Carcinoma</i> (c) <i>Arterial Embolus, Popliteal, Right</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>6 weeks</i> <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> 19 <i>61</i> to <i>1/28</i> 19 <i>61</i> , that (I) was lost saw the deceased alive on <i>1/28</i> 19 <i>61</i> , and that death occurred at <i>7:28</i> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>G. W. Prichard</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>G. W. PRICHARD M.D.</i>		22d. ADDRESS <i>Glen Burnie, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/31/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore 25, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley</i>		25a. REC'D BY REGISTRAR <i>FEB 1 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles E. H...</i>			

1915

CERTIFICATE OF DEATH

115

[Faint, mostly illegible text from the reverse side of the document, including fields for name, date, and cause of death.]

FOR STATE HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Same b. COUNTY Same		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 1b 3/12	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 90 Linda Lane			d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) George A. Shaw			4. DATE OF DEATH Month Jan Day 19 Year 1961		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 /14/95		9. AGE (in years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Presque Isle, Maine	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME George Shaw		
14. MOTHER'S MAIDEN NAME Noira Roach			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 206-07-5211			17. INFORMANT Major James McManus (Son-In-Law)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert MD			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) GUSTAVE H. FAUBERT MD			DATE SIGNED 1/19/61		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 20th Jan. '61	22c. NAME OF CEMETERY OR CREMATORY St. Louis Cath. Ch. Cem.		22d. LOCATION (City, town, or county) (State) Limestone, Maine
23. FUNERAL DIRECTOR'S SIGNATURE A. V. King			ADDRESS Glen Burnie, Maryland		24a. REC'D BY REGISTRAR DATE JAN 24 '61
24b. REGISTRAR'S SIGNATURE Arthur S. King					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60155

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West River c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shadyside Road				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West River d. STREET ADDRESS Shadyside Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle WOLFORD Last SHINNICK				4. DATE OF DEATH Month January Day 27 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 14, 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DIET MAKER		10b. KIND OF BUSINESS OR INDUSTRY PAPER BOX INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JRMSBY SHINNICK				14. MOTHER'S MAIDEN NAME Martin Jane Eskridge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 183-01-3240		17. INFORMANT MINNA L. SHINNICK Address Chalk Point, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Arteriosclerotic Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/28/61	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 31, 1961		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		22d. LOCATION (City, town, or country) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR T A Hardesty & Son ADDRESS Galesville, Md				24a. REC'D BY REGISTRAR FEB 1 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 8

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

154
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00082

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. LENGTH OF STAY IN 1b
2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Eliza Middle SIMMS Last SIMMS | | 4. DATE OF DEATH
Month January Day 10 Year 19 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec 1, 1906 |
| 9. AGE (In years last birthday)
54 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Tobacco Farmer | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
UNKNOWN | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Joe Simms Address Harwood - Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease
DUE TO (c) Respiratory Failure | | INTERVAL BETWEEN ONSET AND DEATH
1 wk | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) the hospital attended the deceased from Jan. 8, 19 61 to Jan. 10, 19 61 that (I) XX last saw the deceased alive on Jan. 9, 19 61 , and that death occurred at 4:00 A.M. M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
A. T. Allen | | 22b. DATE SIGNED
1/10/61 | |
| 22c. PHYSICIAN'S NAME (Type)
A. T. Allen | | 22d. ADDRESS
62 Cathedral St., Annapolis, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
1-14-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Chews Chapel | | 23d. LOCATION (City, town, or county) (State)
West River, Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
TA Hardesty & Son | | 25a. REC'D BY REGISTRAR
Galeville, Md | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Farris | | DATE FEB 7 '61 | |

CERTIFICATE OF DEATH

154

60082

Name of deceased: [illegible]

Sex: [illegible]

Age: [illegible]

Date of death: [illegible]

Dec 1902

for [illegible] - [illegible]

Jan. 10, 1903

Jan. 10, 1903

[illegible]

For [illegible] [illegible] [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00156

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

X

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A. A.</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>
c. LENGTH OF STAY IN 1b <u>10</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>912 Smithfield Street</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>A. A.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>
d. STREET ADDRESS <u>912 Smithfield</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Jarvie</u> First <u>Snowden</u> Middle <u></u> Last <u></u> | | 4. DATE OF DEATH
Month <u>1</u> Day <u>6</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-10-1887</u> 73 yrs. |
| 9. AGE (In years last birthday) <u>73</u> | | 10. IF UNDER 1 YEAR
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | 11. IF UNDER 24 HRS.
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 13. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 14. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 15. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 16. FATHER'S NAME <u>Herbert Parker</u> | | 17. MOTHER'S MAIDEN NAME <u>Elizabeth Brandford</u> | |
| 18. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> | | 19. SOCIAL SECURITY NO. <u></u> | |
| 20. INFORMANT <u>George Snowden</u> | | 21. ADDRESS <u>69 N. West St.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cu die</u>
<u>434.4</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u>
(c) <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u></u> a. m. <u></u> p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>E. L. Linhart</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-6-61</u> | |
| EXAMINER'S NAME (Type) <u>E. L. Linhart</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-10-1961</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> | | 24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u></u> | |
| DATE <u>JAN 11 '61</u> | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
156 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8,9,11,12 File G279 1-16-61 et

Reg. Dist. No.

00157

| | | | | | |
|--|---------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis-MD.</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis-</u> <u>10</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u> | | | d. STREET ADDRESS <u>Box 422 - Rt 2 - Ch. Annapolis - Rd</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>DARNEIL K Sommerville</u> | | | 4. DATE OF DEATH
Month <u>1</u> Day <u>7</u> Year <u>1961</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 27, 1959</u> | | 9. AGE (In years last birthday) <u>1</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>John W. Sommerville</u> | | | 14. MOTHER'S MAIDEN NAME <u>Blondy Odem</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>John W. Sommerville</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>1-2-3rd degree Burns</u>
<u>916.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u> hours. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lived at home</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>8:30 p.m. 1-7 1961</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>ACW</u> (County) <u>MD</u> (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>1-7-61</u> | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Jan 10 1961</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Carver's Hill</u> | |
| 22d. LOCATION (City, town, or county) <u>Annapolis</u> | | 22e. (State) <u>MD</u> | | 22f. (City, town, or county) <u>Annapolis</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold J. Johnson</u> | | ADDRESS <u>Annapolis</u> | | 24a. REC'D BY REGISTRAR <u>JAN 10 61</u> DATE | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneel</u> | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

157
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>AACO</u> | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>ANNEPOLIS-MD.</u> | | | c. LENGTH OF STAY IN 1b
<u>—</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>ANNE ARUNDAL GENERAL</u> | | | d. STREET ADDRESS
<u>Box 422 Rt. 2 - Cellanville Rd</u> | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MARY</u> Middle <u>LOUISE</u> Last <u>Sommerville</u> | | | 4. DATE OF DEATH
Month <u>1</u> Day <u>8</u> Year <u>1961</u> | | |
| 5. SEX <u>F</u> | | | 6. COLOR OR RACE <u>C</u> | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
<u>APR 23/58</u> | | |
| 9. AGE (in years last birthday)
<u>2</u> yrs. | | | 10. IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> | | |
| 11. IF UNDER 24 HRS.
Hours <u>—</u> Min. <u>—</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore City, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>John W. Sommerville</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Olenor Oden</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. <u>—</u> | | |
| 17. INFORMANT
<u>John W. Sommerville</u> | | | Address
<u>Jones Station</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>1-2-3rd degree Burn</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Fall at home</u> | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>8:00 p.m. 1-7 1961</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | | 20f. (City or town) (County) (State)
<u>A.A. Co MD</u> | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
<u>E. L. Wharft.</u> | | | DATE SIGNED
<u>1/8/61</u> | | |
| EXAMINER'S NAME (Type)
<u>E. L. Wharft.</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial Jan. 18 1961</u> | | | 22b. DATE THEREOF | | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Carpenter's Hill</u> | | | 22d. LOCATION (City, town, or country) (State)
<u>Jones Station, A.A. Co</u> | | |
| 23. FUNERAL DIRECTOR
<u>Arnold A. Johnson</u> | | | 24a. REC'D BY REGISTRAR
<u>John L. Kline</u> | | |
| ADDRESS
<u>Annapolis</u> | | | 24b. REGISTRAR'S SIGNATURE | | |

JAN 10 '61

RECEIVED
DEPT. OF AGRICULTURE
WASHINGTON, D. C.

12-2-1911

RECEIVED

F. C. [illegible]
[illegible]
[illegible]

[illegible]

[illegible]

X

X

12/2/11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

158

CERTIFICATE OF DEATH

Reg. Dist. No.

01484

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>AA.CC.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>258 WEST ST.</u> | | d. STREET ADDRESS <u>1258 WEST ST</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>IDELLA</u> Middle <u>SWEENEY</u> Last <u>JAN.</u> | | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>27</u> Year <u>1961</u> | |
| 5. SEX <u>7</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/22/88</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HWF</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>PRINCE GEO. CO.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>THOMAS SIMPSON</u> | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH PEACOCK</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Annapolis, Md.</u> | | <u>ROSE L. HARDESTY. 258 West St.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ac. Heart Failure</u>
DUE TO <u>443X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis C.V. Disease</u>
DUE TO <u>hypertension</u>
(c) <u>yes</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Jan 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>61</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Mamie Klamans</u> M.D. | | ADDRESS (Street, city or town, state) <u>31 Southgate Ln</u> DATE SIGNED <u>1/27/61</u> | |
| PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAMANS</u> | | <u>Annapolis, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1/30/61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home—Upper Marlboro,</u> | | 24a. REC'D BY REGISTRAR <u>Feb 14 '61</u> 24b. REGISTRAR'S SIGNATURE <u>William L. Thayer</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

159

CERTIFICATE OF DEATH

C0159

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MARYLAND</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>
c. LENGTH OF STAY IN lb <u>10</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>93 Conduit St</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>aa</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>
d. STREET ADDRESS <u>93 Conduit</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Joseph</u> Middle <u>A</u> Last <u>TARLETON</u> | | 4. DATE OF DEATH
Month <u>January</u> Day <u>19</u> Year <u>1961</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH <u>1879</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u> | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>Jerome Tarleton</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Margaret Dougherty</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>JAMES TARLETON #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO (b) <u>493 X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Heart failure</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) <u>Annapolis</u> | | (County) <u>Md</u> | | (State) <u>Md</u> | | | |
| 21. I certify that (I) (the undersigned) attended the deceased from <u>January 19, 1958</u> , to <u>Jan. 19, 1961</u> that (I) (we) saw the deceased alive on <u>Jan. 19, 1961</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>John L. Hedeman</u> | | 22b. DATE SIGNED
<u>1/21/61</u> | | 22c. PHYSICIAN'S NAME (Type) <u>John L. Hedeman</u> | | | |
| 22d. ADDRESS
<u>121 Cathedral St., Annapolis, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>1-23-1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cent</u> | | | |
| 23d. LOCATION (City, town or county) <u>Annapolis</u> | | (State) <u>Md</u> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John W. Taylor Sons</u> | | 25a. REC'D BY REGISTRAR
<u>Jan 25 '61</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kress</u> | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

160

60160

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|--|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Annapolis</u> | | c. LENGTH OF STAY IN lb
<u>5 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X <u>RURAL - Annapolis</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Anne Arundel General Hospital</u> | | | | d. STREET ADDRESS
<u>Rt-2, Box-347</u> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Theret (THERROTTE) T. TAYLOR</u> | | | | 4. DATE OF DEATH Month Day Year
<u>January 24 1961</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 8, 1899</u> | | 9. AGE (In years last birthday)
<u>61 yrs.</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>AGRONOMIST</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S GOLF ASSO</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | | |
| 13. FATHER'S NAME
<u>JOHN T. TAYLOR</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARTHA BISHOP</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give year or dates of service) | | 16. SOCIAL SECURITY NO.
<u>097-01-565</u> | | 17. INFORMANT
<u>EVALYN R. TAYLOR</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u>
464 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>THROMBOPHLEBITIS RT. ILLAC VEIN</u>
DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>IMMEDIATE</u>
<u>5 DAYS</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA PANCREAS</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (the informant) attended the deceased from <u>1-18-61</u> to <u>1-24-61</u> , that (I) (the informant) last saw the deceased alive on <u>1-24-1961</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Edward S. Beck</u> M.D.
22b. PHYSICIAN'S NAME (Type)
<u>Edward S. Beck</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS
<u>71 Franklin St., Annapolis, Md.</u> | | | |
| 22b. DATE SIGNED
<u>1/24/61</u> | | | | | | | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>1-27-1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>White Hall Cemt</u> | | | |
| 23d. LOCATION (City, town or county) (State)
<u>St Marguerite AAC Md</u> | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Taylor Sr</u> | | ADDRESS
<u>Annapolis Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 30 '61</u> | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Evans</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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| 1. PLACE OF DEATH
a. COUNTY
ANNE ARUNDEL | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MD. | | b. COUNTY
A. A. Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Linthicum Hgts. | | c. LENGTH OF STAY IN 1b
44 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Linthicum Hgts. Near Burnie X P.O. | | d. STREET ADDRESS
315 HAMMONDS FERRY ROAD - NORTH | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
315 HAMMONDS FERRY ROAD - NORTH | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Estella M. Towson | | First Middle Last
Estella M. Towson | | 4. DATE OF DEATH
Month Day Year
Jan 1 1961 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 10 1893 | |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
BALTO, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Holtritter | | 14. MOTHER'S MAIDEN NAME
Mary - (Unknown) | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
216-18-3807 | | 17. INFORMANT
Mrs. Ross Jordan - Same as #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
ISIX DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma (adenocarcinoma) of Stomach Anterior
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. Month Day Year
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 27, 1960 to January 1, 1961 , that (I) (we) last saw the deceased alive on January 1, 1961 , and that death occurred at 7:00 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
E. Roderick Shipkey | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
January 3, 1961 | | | |
| 22c. PHYSICIAN'S NAME (Type)
E. Roderick Shipkey M.D. | | 22d. ADDRESS
529 Camp Meade Rd, Linthicum Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Jan. 4 - 61 | | 23c. NAME OF CEMETERY OR CREMATORY
London Park Cemetery | | 23d. LOCATION (City, town, or county) (State)
BALTO, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Robert P. Singleton | | ADDRESS
Glen Burnie Md | | 25a. REC'D BY REGISTRAR
DATE JAN 5 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur E. H. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

162

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00162

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Crownsville State Hospital | | d. STREET ADDRESS
3834 Eagle Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Last Tripps | | 4. DATE OF DEATH
Month 1 Day 3 Year 19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 28 1893 |
| 9. AGE (In years, months, days, hours, minutes)
67 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired)
Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jacob Tripps | | 14. MOTHER'S MAIDEN NAME
Francis J. ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
491X IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome associated with Generalized Arteriosclerosis | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. ----- 19
p. m. ----- | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State)
11/11/60 1/3/61 | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/3/61 to 1/3/61 , that (I) (we) last saw the deceased alive on 1/3/61 , and that death occurred at 6:55 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
L. Benedict, M. D. | | 22b. DATE SIGNED
January 3, 1961 | |
| 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | 22d. ADDRESS
Crownsville State Hospital, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
1-7-61 | | 23b. DATE THEREOF
1-7-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt Auburn | | 23d. LOCATION (City, town, or county) (State)
Baltimore Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
George E. Nelson | | 24a. REC'D BY REGISTRAR
Jan 5 '61 | |
| ADDRESS
1348 N. Calhoun | | 25b. REGISTRAR'S SIGNATURE
Charles S. House | |

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may be signed by the attending physician and completely filled out by the funeral director, after this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

163

00163

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville | | | c. LENGTH OF STAY IN 1b
11 years
5 mos. 9 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital | | | | d. STREET ADDRESS
Camp Parole | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle _____ Last Tyler | | 4. DATE OF DEATH
Month 1 Day 8 Year 1961 | | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-3 1899 | 9. AGE (In years (Inday) yrs.)
62 | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Hospital Records Address _____ | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Inanition & Dehydration
DUE TO Chronic Brain Syndrome Associated with Central Nervous System Syphilis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO _____
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/29 19 49 , to 1/8/ 19 61 , that (I) (we) last saw the deceased alive on 1/8/ 19 61 and that death occurred at 6:30 PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>[Signature]</i> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 1/9/61 | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | 22d. ADDRESS
Crownsville State Hospital, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1-13-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Brewer Hill | | 23d. LOCATION (City, town, or county) (State)
Annapolis, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>[Signature]</i> | | | | ADDRESS
Annapolis, Md. | | 25a. REC'D BY REGISTRAR
JAN 11 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
164
CERTIFICATE OF DEATH

60170

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|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Atchafalco Highway & Earleigh Rd</u> | | d. STREET ADDRESS <u>Atchafalco Highway & Earleigh Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Frank Anthony Wagner</u> | | 4. DATE OF DEATH <u>1-24-61</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 26, 1893</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Industrious</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Frank A. Wagner</u> | | 14. MOTHER'S MAIDEN NAME <u>Hartstone</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT <u>Wife</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u>
<u>180X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Kidney</u> DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 to <u>1961</u> 19, that (I) (we) last saw the deceased alive on <u>5-20-1961</u> and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert R. HAHN</u> M.D. | | 22b. DATE SIGNED <u>1-24-61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u> | | 22d. ADDRESS <u>P.O. Box 73 Severna Park Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>13</u> | 23b. DATE THEREOF <u>1-27-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u> | 23d. LOCATION (City, town, or county) (State) <u>Brooklyn Md</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>McClary</u> | | 25a. REC'D BY REGISTRAR <u>JAN 25 '61</u> | |
| ADDRESS <u>Funeral Home 130 E. Fort St</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | |

100

CERTIFICATE OF DEATH

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 of 2 should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
165
CERTIFICATE OF DEATH

00164

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|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <i>aa</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. C. General</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>md.</i>
b. COUNTY <i>aa</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>
d. STREET ADDRESS <i>R. F. D.</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Pauline</i> Middle <i>E.</i> Last <i>Walston</i> | | 4. DATE OF DEATH
Month <i>1</i> Day <i>13</i> Year <i>1961</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Mar-31-1914</i> |
| 9. AGE (In years last birthday) <i>46</i> yrs. | | IF UNDER 1 YEAR
Months <i>4</i> Days <i>13</i> Hours <i>13</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Wilmington N. C.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Bertha Garganus</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>William C. Walston</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>gangrenous small bowel</i>
DUE TO (b) <i>thrombosing superior mesenteric artery</i>
DUE TO (c) <i>directing aneurysm of aorta</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Mixed arteriosclerosis + atherosclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>18 hr.</i>
<i>18 hr.</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1-13-61</i> to <i>1-13-61</i> , that (I) (we) last saw the deceased alive on <i>1-13-61</i> , and that death occurred at <i>AM</i> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Frank M Shipley</i> | | 22b. DATE SIGNED <i>1-14-61</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i> | | 22d. ADDRESS <i>Annapolis, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | | 23b. DATE THEREOF <i>1-17-1961</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) <i>Tarboro N. C.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Julius M. Saylor Sr</i> | | 25a. REC'D BY REGISTRAR <i>JAN 16 '61</i> | |
| ADDRESS <i>Annapolis Md.</i> | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

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STATION TO STATION

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CERTIFICATE OF DEATH

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Reg. Dist. No.

166

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|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <i>aa</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Md</i> b. COUNTY <i>aa</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Millersville</i> | | | | c. LENGTH OF STAY IN 1b
<i>X</i> <i>Millersville</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Harriett</i> Middle <i>E.</i> Last <i>Ward</i> | | | | 4. DATE OF DEATH
Month <i>1</i> - Day <i>12</i> Year <i>1961</i> | | | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>8-13-1890</i> | |
| 9. AGE (In years lost birthday) yrs. <i>70</i> | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | | | |
| 13. FATHER'S NAME
<i>Charles Higgs</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Elliz Ward</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Charles Ward</i> Address <i>#2</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Heart failure</i>
<i>422.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, conduction system disease</i>
DUE TO (c) <i>Arteriosclerosis</i>
INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>5 yrs</i>
<i>5 yrs</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>July</i> , 19 <i>53</i> , to <i>Jan</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>Jan 9</i> , 19 <i>61</i> , and that death occurred at <i>4:45</i> M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <i>John Hedeman</i> M.D. | | | | 1/12/61 | | | |
| PHYSICIAN'S NAME (Type) <i>John Hedeman</i> | | | | <i>Annapolis Md.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>1-14-1961</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>Edwards Chapel</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Annapolis Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>John H. Layla & Sons</i> | | | | ADDRESS
<i>Annapolis Md.</i> | | 24a. REC'D BY REGISTRAR
DATE <i>JAN 16 '61</i> | |
| 24b. REGISTRAR'S SIGNATURE
<i>Charles E. Kline</i> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6,7 Film G278 1-10-61 et

167

CERTIFICATE OF DEATH

C0166

Reg. Dist. No.

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH
o. COUNTY <i>Ann Arundel</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>md</i> b. COUNTY <i>Anne</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elk River md</i> | | c. LENGTH OF STAY IN 1b <i>40 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Nellie D. Webb</i> | | 4. DATE OF DEATH <i>Jan 2 1961</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>April 23-1894</i> |
| 9. AGE (In years last birthday) <i>66</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>yes</i> | |
| 13. FATHER'S NAME <i>Andrew D. Dunsen</i> | | 14. MOTHER'S MAIDEN NAME <i>Hannah O. Wayfield</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>157X Carcinoma Pancreas</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>July</i> , 19 <i>19</i> , to <i>12/1/61</i> , 19 <i>61</i> , that I lost saw the deceased alive on <i>11/1/61</i> , 19 <i>61</i> , and that death occurred at <i>2:45</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>J. Brady Smith</i> M.D. | | ADDRESS (Street, city or town, state) <i>9471 4th. Smallwood Rd. Pasadena, Md.</i> DATE SIGNED <i>1/2/61</i> | |
| PHYSICIAN'S NAME (Type) <i>J. BRADY SMITH</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>Jan 5-1961</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Elk River</i> | 22d. LOCATION (City, town, or county) (State) <i>Patterson Blk Brown md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald A. Frank</i> ADDRESS <i>Elk River md</i> | | 24a. REC'D BY REGISTRAR DATE <i>JAN 5 '61</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i> | |

10000

STANDARD STATEMENT OF HEALTH - BIRTH

CERTIFICATE OF DEATH

100

[Faint, illegible text, likely bleed-through from the reverse side of the document]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

60088

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Laurel
c. LENGTH OF STAY IN 1b
31 years
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION
District Training School Children's Center | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
Washington, D.C.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First
John
Middle
Robert
Last
Weil | | 4. DATE OF DEATH
Month
January
Day
30
Year
1961 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 10, 1898 |
| 9. AGE (In years last birthday)
62 yrs. | | 10. IF UNDER 1 YEAR
Months
62 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Institutionalized | | 10b. KIND OF BUSINESS OR INDUSTRY
unknown | |
| 11. BIRTHPLACE (State or foreign country)
unknown | | 12. CITIZEN OF WHAT COUNTRY?
unknown | |
| 13. FATHER'S NAME
Fred Weil | | 14. MOTHER'S MAIDEN NAME
Emma Weil | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
no | |
| 17. INFORMANT
Children's Center, Laurel, Md. | | Address
Children's Center, Laurel, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
Bilateral pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Mental retardation | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | |
| 21. I certify that I attended the deceased from 1-29-1961 to 1-30-1961 , that I last saw the deceased alive on 1-30-1961 , and that death occurred at 5:10 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Stephen W. DeJter | | ADDRESS (Street, city or town, state)
Children's Center, Laurel, Md.
DATE SIGNED
1/31/61 | |
| PHYSICIAN'S NAME (Type)
Stephen W. DeJter | | Children's Center, Laurel, Md.
1/31/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb 2, 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY
District Training School | | 22d. LOCATION (City, town, or county)
Laurel, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Howell, Jr. Supt DTS Laurel, Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 8 '61 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | | |

CERTIFICATE OF DEATH

100

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through from the reverse side.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
169
CERTIFICATE OF DEATH

C0167

| | | | |
|--|---------------------------|---|--------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville | | c. LENGTH OF STAY IN 1b
10 mo. 12 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital | | d. STREET ADDRESS
946 Hamburg Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First
Mamie
Middle
Louise
Last
Westbury | | 4. DATE OF DEATH
Month
1
Day
13
Year
1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1903 |
| 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months
Days
Hours
Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
South Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Anthony Jones | | 14. MOTHER'S MAIDEN NAME
Sarah ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
Unknown | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive and Arteriosclerotic Cardiovascular Disease
DUE TO (c) Senility | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Generalized Arteriosclerosis and Senility | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. -----
p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/1 1960 to 1/13 1961, that (I) (we) last saw the deceased alive on 1/13 1961, and that death occurred at 8:10 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature]
M.D. | | 22b. DATE
1/13/61 | |
| 22c. PHYSICIAN'S NAME (Type)
L. Benedict, M. D. | | 22d. ADDRESS
Crownsville State Hospital, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1/17/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY
MARTINTOWN | | 23d. LOCATION (City, town, or county) (State)
LEE CO. S.C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
[Signature]
ADDRESS
638 E. Ebbett St | | 25a. REC'D BY REGISTRAR
DATE
JAN 16 '61 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

Received of the Treasurer of the
City of New York the sum of \$100.00

2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C0168

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town)
ANNAPOLIS | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNAPOLIS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
A. A. GENERAL HOSPITAL | | d. STREET ADDRESS
108 TOLSON ST. | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
JOAN First CAROL Middle WHEELER Last | | 4. DATE OF DEATH
JAN 31 1961 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JULY 23 1932 |
| 9. AGE (In years last birthday)
28 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BACTERIOLOGIST | | 10b. KIND OF BUSINESS OR INDUSTRY
MD STATE DEPT HEALTH ANNAPOLIS MD. | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ALFRED W. WHEELER | | 14. MOTHER'S MAIDEN NAME
A. JEANNE TYDINGS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
ALFRED W. WHEELER | | Address
2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture Skull
825x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crushed Chest.
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Auto Accident | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 1:31 p. m. 1961 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Highway | 20f. (City or town) (County) (State)
BALCO MD |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
E. L. IN HAND | | DATE SIGNED
1-31-61 | |
| EXAMINER'S NAME (Type)
E. L. IN HAND | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
FEB. 4, 1961 | 22c. NAME OF CEMETERY OR CREMATORY
HILLCREST | 22d. LOCATION (City, town, or county) (State)
ANNAPOLIS MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
JOHN M. TAYLOR, Sons ANNAPOLIS MD | | 24a. REC'D BY REGISTRAR
FEB 6 '61 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. Name of Deceased | | 2. Sex | | 3. Age | |
| 4. Date of Death | | 5. Time of Death | | 6. Place of Death | |
| 7. Cause of Death | | 8. Manner of Death | | 9. Signature of Medical Examiner | |
| 10. Signature of Coroner | | 11. Signature of Registrar | | 12. Signature of Burial Officer | |
| 13. Signature of Undertaker | | 14. Signature of Funeral Home | | 15. Signature of Cemetery | |
| 16. Signature of Church | | 17. Signature of Minister | | 18. Signature of Rector | |
| 19. Signature of Pastor | | 20. Signature of Priest | | 21. Signature of Rabbi | |
| 22. Signature of Imam | | 23. Signature of Minister of Religion | | 24. Signature of Other Religious Officer | |
| 25. Signature of Other Religious Officer | | 26. Signature of Other Religious Officer | | 27. Signature of Other Religious Officer | |
| 28. Signature of Other Religious Officer | | 29. Signature of Other Religious Officer | | 30. Signature of Other Religious Officer | |
| 31. Signature of Other Religious Officer | | 32. Signature of Other Religious Officer | | 33. Signature of Other Religious Officer | |
| 34. Signature of Other Religious Officer | | 35. Signature of Other Religious Officer | | 36. Signature of Other Religious Officer | |
| 37. Signature of Other Religious Officer | | 38. Signature of Other Religious Officer | | 39. Signature of Other Religious Officer | |
| 40. Signature of Other Religious Officer | | 41. Signature of Other Religious Officer | | 42. Signature of Other Religious Officer | |
| 43. Signature of Other Religious Officer | | 44. Signature of Other Religious Officer | | 45. Signature of Other Religious Officer | |
| 46. Signature of Other Religious Officer | | 47. Signature of Other Religious Officer | | 48. Signature of Other Religious Officer | |
| 49. Signature of Other Religious Officer | | 50. Signature of Other Religious Officer | | 51. Signature of Other Religious Officer | |
| 52. Signature of Other Religious Officer | | 53. Signature of Other Religious Officer | | 54. Signature of Other Religious Officer | |
| 55. Signature of Other Religious Officer | | 56. Signature of Other Religious Officer | | 57. Signature of Other Religious Officer | |
| 58. Signature of Other Religious Officer | | 59. Signature of Other Religious Officer | | 60. Signature of Other Religious Officer | |
| 61. Signature of Other Religious Officer | | 62. Signature of Other Religious Officer | | 63. Signature of Other Religious Officer | |
| 64. Signature of Other Religious Officer | | 65. Signature of Other Religious Officer | | 66. Signature of Other Religious Officer | |
| 67. Signature of Other Religious Officer | | 68. Signature of Other Religious Officer | | 69. Signature of Other Religious Officer | |
| 70. Signature of Other Religious Officer | | 71. Signature of Other Religious Officer | | 72. Signature of Other Religious Officer | |
| 73. Signature of Other Religious Officer | | 74. Signature of Other Religious Officer | | 75. Signature of Other Religious Officer | |
| 76. Signature of Other Religious Officer | | 77. Signature of Other Religious Officer | | 78. Signature of Other Religious Officer | |
| 79. Signature of Other Religious Officer | | 80. Signature of Other Religious Officer | | 81. Signature of Other Religious Officer | |
| 82. Signature of Other Religious Officer | | 83. Signature of Other Religious Officer | | 84. Signature of Other Religious Officer | |
| 85. Signature of Other Religious Officer | | 86. Signature of Other Religious Officer | | 87. Signature of Other Religious Officer | |
| 88. Signature of Other Religious Officer | | 89. Signature of Other Religious Officer | | 90. Signature of Other Religious Officer | |
| 91. Signature of Other Religious Officer | | 92. Signature of Other Religious Officer | | 93. Signature of Other Religious Officer | |
| 94. Signature of Other Religious Officer | | 95. Signature of Other Religious Officer | | 96. Signature of Other Religious Officer | |
| 97. Signature of Other Religious Officer | | 98. Signature of Other Religious Officer | | 99. Signature of Other Religious Officer | |
| 100. Signature of Other Religious Officer | | 101. Signature of Other Religious Officer | | 102. Signature of Other Religious Officer | |

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

171 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|------------------------------------|---|--------------------------------------|---|--------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Severna Park | | d. STREET ADDRESS
Jones Station | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Anne Arundel General Hospital | | | | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
ROSAMAE H. WILSON | | First Middle Last | | 4. DATE OF DEATH
January 14, 1961 | | Month Day Year | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH
5-22-1932 | 9. AGE (In years last birthday)
28 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert Williamson | | | | 14. MOTHER'S MAIDEN NAME
Emma Hunt | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
James Wilson 9 Pinkney St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Transection of cervical spine
DUE TO
812X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Pedestrian struck by auto | | | | | |
| 20c. TIME OF INJURY
Hour 10:05 p.m. Month, Day, Year 1/14/61 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Road | | 20f. (City or town) (County) (State)
Severna Park Anne Arundel Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED
1/16/61 | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1-20-61 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Marys | | 22d. LOCATION (City, town, or county) (State)
Annapolis Md. | |
| FUNERAL DIRECTOR
William Reese | | ADDRESS
Annapolis Md. | | 24a. REC'D BY REGISTRAR
Arthur S. Hanna | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | |

60169

1000

170 MEDICAL EXAMINER, COMPOSITE OF STATE

THE STATE
OF NEW YORK

James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

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James A. [unclear]

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James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

James A. [unclear]

172

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00171

| | | | |
|--|------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Se, e
b. COUNTY
Same | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pasadena | | c. LENGTH OF STAY IN 1b
2 1/2 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Oldmill Rd. | | d. STREET ADDRESS
Same | |
| 3. NAME OF DECEASED
(Type or print)
Regina Louise Wright | | 4. DATE OF DEATH
Jan. 22rd. 1961 | |
| 5. SEX
F | 6. COLOR OR RACE
C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/3/50 |
| 9. AGE (In years last birthday)
10 yrs. | | 10. IF UNDER 1 YEAR
Months 10 Days 10 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Pupil | | 12. KIND OF BUSINESS OR INDUSTRY
Pasadena Md. | |
| 13. FATHER'S NAME
Milton Robert Wright | | 14. MOTHER'S MAIDEN NAME
Dolores Parker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
Ernest Green (step father) | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Suffocation by smoke
9/16.8 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b)
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
Was trapped in second floor of her home which was burned down. | |
| 20c. TIME OF INJURY
Hour a.m. 11:24 p.m. Month, Day, Year 1/22/61 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Pasadena A.A. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Gustave H. Faubert | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Gustave H. Faubert M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1-27-61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Church Ct. | | 22d. LOCATION (City, town, or country) (State)
Maryland A.A. Co. Md. | |
| 23. FUNERAL DIRECTOR
Frank L. Brown, Baltimore 30 Md. | | 24a. REC'D BY REGISTRAR
DATE JAN 27 '61 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. K... | | 24c. REGISTRAR'S SIGNATURE
Arthur S. K... | |

VS. A15ME
5M 7/59

MAKING STATE DEPARTMENT OF HEALTH
UNION STATISTICAL BUREAU AND RECORDS FOR MRS. JONAS
10111

10111

Printed by the Government Printing Office
Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00092

173

| | | | | | | | |
|--|--|--------------------------------------|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNAPOLIS, MARYLAND | | | | c. LENGTH OF STAY IN 1b
2 DAYS | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNAPOLIS | | | | d. STREET ADDRESS
56 MADISON PLACE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First BABY BOY "A" Middle ZIMMERMAN Last ZIMMERMAN | | | | 4. DATE OF DEATH
Month JAN Day 1 Year 19 61 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAUC | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-30-60 | |
| 9. AGE (In years last birthday)
yrs. 2 | | IF UNDER 1 YEAR
Months 2 | | IF UNDER 24 HRS.
Days 2 Hours 2 Min. 1 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)
- - - - - | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- - - - - | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | | | | | |
| 13. FATHER'S NAME
DAVID LEE ZIMMERMAN | | | | 14. MOTHER'S MAIDEN NAME
SHIRLEY MAY TAYBURN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
- - - | | 17. INFORMANT
U. S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY DISTRESS
DUE TO PREMATURITY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
773.5 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 DAYS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. 1 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 12-30 , 19 60 , to 1-1 , 19 61 , that I last saw the deceased alive on 1-1 , 19 61 , and that death occurred at 1:30 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. M. Cann | | | | ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | | | |
| PHYSICIAN'S NAME (Type) LT JOHN J. MC CANN MC USNR | | | | DATE SIGNED 1-1-61 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1-3-1961 | | 22c. NAME OF CEMETERY OR CREMATORY
U.S. Naval Academy | | 22d. LOCATION (City, town, or county) (State)
ANNAPOLIS MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John M. Taylors Sons | | | | ADDRESS
Annapolis, Md. | | 24a. REC'D BY REGISTRAR
DATE JAN 5 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

MEDICAL CERTIFICATION

2151120XVO

